Four Seasons Health Care (England) Limited

East Riding Care Home

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

About the service: East Riding Care Home provides personal and nursing care for up to 67 people. On day one of the inspection 43 people were living at the service. The home has two floors and supports people who may be living with a dementia.

People's experience of using this service: Medicines were not managed safely. We could not be sure people received their medicines as prescribed.

Staff told us there were not enough staff to support people in a timely manner. Inspectors had to look for staff on several occasions as people needed support.

The environment was not safe for its intended use. Maintenance checks had not been routinely completed and nurse call bells were tied up out of people's reach. Staff were concerned about how they would evacuate people in the event of a fire.

There were concerns in relation to meeting people's nutrition and hydration needs.

Care records were not always accurate or up to date. Risks to people had not always been mitigated.

Management checks were not sufficiently robust to drive improvement.

There was limited evidence of a person-centred culture and visitors shared concerns around communication and management.

Staff had a caring nature and treated people with kindness however engagement and interaction was limited due to the numbers of staff on shift.

Activities were varied and people were supported to engage with the local community on days out.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection: At the last inspection the service was rated requires improvement. (Report published 12 September 2018).

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe and well-led to at least good. During this inspection we found the required improvements had not been made.

Why we inspected: The inspection at East Riding Care Home was brought forward due to the receipt of information of concern. These included concerns around staffing, provision of care, nutrition, hygiene and

premises. This inspection examined those risks and we shared the concerns with the local safeguarding and commissioning team. East Riding Care Home is currently within the local authority organisational safeguarding framework.

Enforcement: We identified two ongoing breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 around safe care and treatment and good governance. New breaches in relation to staffing and nutrition and hydration were identified. Please see the Action we told provider to take section towards the end of the report.

We are taking action against the provider for failing to meet the Regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept
under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Follow up: We will continue to monitor the service and will undertake another comprehensive inspection within six months.

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 safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

East Riding Care Home

Detailed findings

Background to this inspection

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

The inspection was prompted by information shared with CQC which indicated potential concerns about the management of risk, staffing levels, care provision and medicine management, nutrition, and premises safety. This inspection examined those risks

The inspection examined those risks and the providers response to them.

Inspection team: The inspection was completed by four adult social care inspectors.

Service and service type: East Riding Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection was unannounced.

What we did: Before the inspection we used information about the service to plan. We reviewed notifications sent us to us about certain incidents that had occurred that the provider must tell us about. We contacted the local authority commissioning and safeguarding teams and the local Healthwatch. Healthwatch are an independent organisation who listen to people's views about local service and drive improvement by sharing those views with organisations who commission, deliver and regulate health and care services.

Due to the responsive nature of this inspection, the provider did not complete a Provider Information Return (PIR). Providers are required to send us key information about their service, what they do well, and

improvements they plan to make. This information helps support our inspections.

Some people who used the service were unable to tell us about their experiences. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we spent time in the communal areas with people chatting and observing. We spoke with two visitors and three people. We spoke with the registered manager, the regional manager and a registered manager from a sister home. We spoke with three nurses and five members of care staff including senior care, care home assistant practitioners and care staff. We also spoke with the activities coordinator, chef and a member of the housekeeping team. We spoke with a volunteer and care staff from two other agencies who worked with East Riding Care Home staff to deliver support.

We reviewed a range of records including seven people's care records, medicine records, three staff records, staff training and supervision and records relating to the management of the service.

During the inspection the provider submitted an action plan in response to the serious concerns letter we sent to them. We also attended an organisational safeguarding meeting with the provider and the local authority. After the inspection the provider sent us updates on the action plan.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.
At the last inspection we found breaches of regulations in relation to premises safety and records relating to medicines management and people's care. During this inspection we found ongoing concerns.

Assessing risk, safety monitoring and management.
• Risks had not always been assessed. People faced risks which should be avoidable.
• One person needed specific equipment for their safety, but this wasn't always available.
• Equipment to ensure people's health and wellbeing was not always available and processes were not in place to assess and monitor certain equipment.
• Fire evacuation procedures were not robust. Staff said they were not trained in the use of evacuation equipment and would use the exterior of the premises as an escape route even though signage said it was unsafe and not to enter. We shared our concerns with the fire service who in response completed a site visit.
• Safety equipment in use had not been well maintained. Some bedroom doors did not fully close which meant they would be less effective in the event of a fire. Nurse call pull cords were tied up and out of people's reach so they could not use them to alert staff if they required help. One sink in a communal toilet had water that was scalding hot.
• Maintenance checks were unavailable to view for all of 2018. The registered manager told us the home had been without a maintenance staff member for some time. They could not show us evidence that essential safety checks had been completed in 2018.

Using medicines safely.
• Medicines were not always administered in line with the prescriber's instructions.
• Guidance for the use of 'as required' medicines were either not in place, or lacked detail to ensure consistent administration. Records were not kept of the outcome of the administration of 'as required medicines.'
• Some records relating to the administration of medicines were not fully completed, there were gaps in the recording of administrations of medicines and some records were not legible.
• It was identified that some people had been incorrectly administered medicines and some medicines had not been administered on several occasions.
• One medicine, a powder which thickens drinks, was not stored securely and was left unattended in a bedroom. This medicine can be fatal if ingested.

Shortfalls in the management of medicines and the safety of the building were highlighted at our last inspection. The provider had failed to make improvements in these areas. This is an ongoing breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Staffing and recruitment.

• There were not enough staff to safely support people. The provider assessed the numbers of staff needed based on people's needs. However, the registered manager told us that, due to the budget, fewer staff were on duty than this assessment tool recommended.
• Staff and relatives raised concerns about the number of staff on duty. One staff member said, "Staffing levels are atrocious." One staff member said of overnight staffing arrangements, "It frightens me. If two staff are supporting one person there is no one observing the other residents." A relative said, "I have discussed staffing levels with (registered manager) as I don't think there are enough to meet (family member's) needs."
• People were seated in communal lounge areas for significant periods of time with no staff presence. Inspectors had to seek the support of staff on multiple occasions to minimise the risk to people. Early morning, when staff responded to an emergency nurse call bell, it left one staff member available to support the other 19 people on that floor,10 of whom would need the support of two staff for any mobility and personal care.
• Safe recruitment practices were followed however not all the records were stored within staff personnel records.

During the last inspection we recommended the provider kept staffing under review to ensure that sufficient staff are deployed at all times. Sufficient numbers of staff were not deployed which placed people at potential risk. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection.
• Systems were in place to prevent and control infection.
• Staff had access to and wore gloves and aprons.
• Some areas of the home were in need of redecoration and maintenance.

Systems and processes to safeguard people from the risk of abuse.
• Accidents, incidents and any safeguarding concerns were recorded on the providers electronic system.
• Staff had attended online training in safeguarding of adults.

Learning lessons when things go wrong.
• After the last inspection the provider submitted an action plan to the commission detailing the improvements that would be made.
• Lessons had not been learnt since the last inspection as we found the provider's action plan had not been fully implemented and concerns were ongoing.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Some regulations were not met.
Staff support: induction, training, skills and experience.
• Staff had not received training in the individual needs of people using the service. Some people living at East Riding Care Home were diagnosed with diabetes, epilepsy or had acquired brain injuries. Staff had not received training in understanding and supporting these specialised conditions.
• One newly recruited member of staff had not attended moving and handling training, so was not able to support people if they needed help with their mobility. However, this member of staff had been included in the numbers of staff on shift which impacted on staff ability to meet people's needs.
• Staff feedback to the provider had been that they required more training, especially in relation to care planning, however here was no evidence this had been reacted to.
• Induction records were not fully completed and required training was not always provided during the induction period.

Concerns in relation to induction and training meant staff competency and skill had not been assessed to ensure they could meet people's care and treatment needs. These concerns are a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

• The providers systems had identified that training and supervision was not meeting the expected standards. The registered manager was responding to this.
• Staff said training was offered and face to face supervisions were held.
• The registered manager had begun supervisions with staff since they had been post in October 2018. We were told there was no log of supervisions completed prior to this time.

Supporting people to eat and drink enough to maintain a balanced diet.
• People's nutritional needs had not been well recorded. Where people required their food and drink to be monitored, staff did not always have information about what targets people should be working to, or what to do if people did not manage this.
• Information for kitchen staff was not complete. It did not always include that people were diabetic and how this might impact on their dietary needs, however the chef was knowledgeable of people's needs.
• Feedback about the quality of meals was varied. Some people told us they enjoyed meals, but others said there were not enough fresh fruit and vegetables. Fresh food was delivered several times a week and the activities coordinator supported people with 'Fruity Friday' where a platter of fresh fruit was available and people were encouraged to join in and enjoy the fruit.

Concerns in relation to people's nutrition and hydration meant we could not be sure people's needs were met. These concerns are a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014. Meeting nutritional and hydration needs.

Staff working with other agencies to provide consistent, effective, timely care.
• Responsibilities were not always clear, and communication could be improved where the provider worked with other care services.
• The registered manager was aware of the arrangements for care provision where several providers were involved, however staff seemed unsure as to the lines of responsibility and accountability. Some concerns were shared with us about the approach to this, and East Riding Care Home staff needed more clarity about what they were accountable and responsible for. We raised this with the registered manager and regional manager.

Adapting service, design, decoration to meet people's needs.
• The environment had not been fully adapted to meet the needs of people with dementia. Some visual signage was on display however there was little to help people to orient themselves. People's doors had not been personalised with a photograph or memory boxes.
• There was limited tactile and sensory equipment available for people to use by themselves.
• Some areas of the home were worn and tired looking and were in need of decoration.
We recommend the provider research best practice in relation to the environment for people living with a dementia.

Supporting people to live healthier lives, access healthcare services and support.
• People were supported to access healthcare services however, it was difficult to identify when follow up action had been completed. For example, some records said a referral to health teams needed to be made but it was not always clear when this had been done and what the outcome was.

Ensuring consent to care and treatment in line with law and guidance; Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• DoLS applications had been made by the current registered manager.
• Records related to mental capacity were not well completed. Information about people's capacity to make decisions was contradictory at times. There was limited evidence of the recording of mental capacity assessments and best interest decisions.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence.
• Staff were very busy. They did not have time to sit and spend time with people. People spent significant periods of time in communal areas with no staff presence. At times we saw staff were rushed and this impacted on the care people received. Staff brought one person, cared for in bed, a cup of tea. They left it out of their reach. We saw the tea went cold and staff had not returned to support the person to drink it.
• When staff were present, we saw they were usually caring and compassionate. Staff were observed to explain things to people before supporting them, bending down so they could speak to people on their level.
• If people were distressed and staff saw this they responded by comforting the person, holding their hand and giving them a hug and telling them everything was alright in a gentle and reassuring manner.
• A person said, "They look after me as well as they can." A relative said, "Staff are lovely, but I am concerned that there aren't enough."
• A staff member from another agency who supported one person said of staff from East Riding Care Home, "They might be under pressure but the staff will always go out of their way if needed. They have a good attitude, that goes a long way. They are trying their best."
• We saw a minority of interactions where staff did not treat people with dignity. One person became very repetitive in their speech. A member of care staff was in the room but did not speak to the person or offer any reassurance. They put their finger to their mouth and made a shush gesture to the person. On a second occasion, another person was becoming distressed by the repetition and the care staff walked out of the room and ignored the situation. Another staff member noted this and checked on the person.

Supporting people to express their views and be involved in making decisions about their care.
• Some visitors were concerned about the decisions made in relation to their family members' care.
• Visitors discussed the approach and communication style used to engage them in their family members' care. They felt the management could be more proactive in approaching and engaging with them.

We have rated caring as requirements improvement. Some of the staff displayed care, kindness and compassion to people however, due to the staffing levels and the deployment of staff it was not always possible for them to provide people with the support needed. Due to the widespread and serious concerns, in relation to staffing levels, risk management and governance we could not be confident the provider's approach was caring.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. One regulation had not been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.
• Care records were difficult to understand. They contained some contradictory information and it was not always clear if they had been reviewed and updated following incidents or changes in people's needs.
• Staff did not always have enough information about people's needs. Diabetes care plans contained limited information about how this should be managed. What people's usual blood sugar levels were, and when staff should take action.
• There was limited information in care records about people's preferences, wishes, interests and life history.
• Care records were not always accurate. One family had highlighted this to staff as their relative's name was misspelt. We shared this with the registered manager.
• Staff they were knowledgeable about people and their needs, however due to the limited time available for them to read care plans and their feedback to the provider that they needed more care plan training, we were not confident that care plans supported staff to meet people's needs.

Concerns in relation to care records meant we could not sure people were receiving person centred care and treatment that was appropriate, met their needs and reflected their wishes. These concerns are a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9. Person centred care.

• People were encouraged to take part in activities, and there was a range of games and events on offer for people.
• The activities co-ordinator was passionate about their role. Staff and relatives praised their work and the positive impact they had on people who used the service.
• Activities were planned around people's preferences and hobbies. The activities coordinator told us they had recently hosted an afternoon tea for one person and their family as they had not been able to go out to the planned activity.

Improving care quality in response to complaints or concerns.
• The registered manager discussed the complaints procedure with us. Acknowledgement letters had been sent to people who had made complaints.
• Some complaints had been upheld and the registered manager and regional manager were open about this and acknowledged that errors had been made and lessons would be learnt.

End of life care and support.
• The quality of end of life care plans differed considerably. Some were very specific to the person, referencing their wishes when they were nearing the end of their life, including their religious beliefs and their preference for specific music.

• Other end of life care plans which could not be found and contained no information on people's preferences or wishes. For one person there was no protocol or information in relation to end of life medicines other than that recorded on a medicine administration record.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.
At the last inspection we found two breaches of regulations. The systems in place to ensure the premises were safe and well maintained were not effective. There were shortfalls in the maintenance of records relating to medicines management and other records relating to people's care. These concerns remained at this inspection. The action plan devised by the provider in response to the findings at our last inspection had not driven improvement.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care.
• Records across the service were not well managed. Records relating to people's care and treatment, staff training and supervision, premises and maintenance were often unavailable, not up to date or accurate and some, relating to medicines were not legible.
• Governance arrangements were not sufficiently robust to tackle shortfalls identified and to drive the required improvements.
• The registered manager completed a daily walk around of the home, however the provider's audit tool to be used to record daily observations and areas for improvement had not been regularly completed.
• The registered manager regularly reviewed care plans, using a tool designed to ensure they were up to date and accurate. Whilst we saw some of these audits highlighted the need for minor amendments, they had not highlighted the large number of records we found which were out of date, difficult to follow, and inaccurate.
• The provider's regional manager visited the home at least monthly and completed an audit designed to highlight any areas for improvement. These audits were not always accurate. In two we viewed from 2018 the audit stated records relating to the maintenance of the building were up to date, however, these were unavailable during our inspection. The audits noted that due to budget reasons, the home was not meeting the requirements of the provider's tool designed to work out how many staff were required based on people's needs.
• During the inspection we found specific, serious concerns in relation to staffing, safe care and treatment, including medicines and premises safety and good governance. On 27 February 2019 we sent a letter of serious concern to the provider. The letter detailed breaches relating to Regulation 12 safe care and treatment, regulation 17 good governance and regulation 18 staffing. We requested reassurances that the risks had been removed or were immediately being removed. On 28 February 2019 we received an action plan from the provider.

The lack of oversight of records had resulted in a failure to assess, monitor and mitigate risks to the health and wellbeing of people using the service. There was a clear failure to ensure accurate, complete and contemporaneous records for each person were maintained. These concerns are a continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good governance.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.
• The registered manager and regional manager were open in their response to our findings. They acknowledged when things had gone wrong and displayed motivation to drive improvements within the home.
• The provider took swift action in response to serious concerns we raised. Their action plan was detailed and thorough about the action they were taking to ensure people were safe and received good care.
• The registered manager was aware of their responsibility related to the duty of candour, an expectation to be open with people when things go wrong. No incidents had occurred which met the threshold for the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.
• People, relatives and staff could provide feedback whenever they wished through an electronic tablet in the main entrance. These comments were reviewed and monitored for trends.
• Feedback had not been used to drive improvement. We saw a board in the entrance detailed that most recent feedback from relatives highlighted their concerns over staffing levels. These issues remained during our inspection.
• People and relatives were invited to meetings to discuss their views on the service.
• Staff feedback showed improvement in morale. Comments from 2018 detailed their concerns about the practice of the previous management team, and the impact that had on people who used the service. Staff comments related to the current registered manager was that there had been a positive shift, as they now felt listened to and that the home was well run.

Working in partnership with others.
• Following our inspection the provider and regional manager worked with us, the local authority and the fire service to make improvements to the service they provided.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users was not always appropriate, met their needs or reflected their preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs There was a failure to ensure the nutritional and hydration needs of service users was met. Regulation 14(1)

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. There was a failure to ensure the proper and safe management of medicines. Risks to the health and safety of service users had not always been assessed and mitigated. There was a failure to ensure the premises was safe to use for its intended purpose. Regulation 12(1); 12(2)(a)(b)(d)(g)

The enforcement action we took:

We served an urgent notice of decision to restrict the admission of new people without written confirmation from the Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established and operated effectively to ensure compliance. There was a failure to maintain accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided ad of decisions taken in relation to the care and treatment provided. Regulation 17(1); 17(2)(a)(b)(c)(d)(ii)

The enforcement action we took:

We served an urgent notice of decision to restrict the admission of new people without written confirmation from the Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed to meet people's needs. Regulation 18(1)

The enforcement action we took:

We served an urgent notice of decision to restrict the admission of new people without written confirmation from the Commission.