Burlington Care Limited

# Bessingby Hall

## Inspection report

Bessingby
Bridlington
Humberside
YO16 4UH

Tel: 01262601362
Website: www.burlingtoncare.com

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## Ratings

| Overall rating for this service | Requires Improvement |
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| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

This inspection took place on 26 October and 6 November 2017. Day one was unannounced and we informed the manager that we would return on day two. At the last inspection in October 2015 the provider had no breaches of regulation.

We moved our planned comprehensive inspection to an earlier date because we had received concerns about a person who had lived at the service from the provider and East Riding of Yorkshire Council (ERYC). Following the inspection we were informed by ERYC of concerns about three further people who had lived at the service. When we carried out our inspection we identified breaches of Regulations 12 Safe Care and Treatment, 13 Safeguarding service users from abuse and improper treatment, 14 Meeting nutritional and hydration needs, 17 Good Governance and 19 Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Bessingby Hall is a care home with nursing that provides accommodation and personal care for up to 65 older people who have physical disabilities and/or are living with a dementia related condition. It is a detached property set out over two floors within its own grounds. There is a separate unit for up to 22 people living with dementia. There were 56 people resident at the service when we inspected.

There was a registered manager employed at this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. They had been registered with CQC since May 2016.

Risks to people had not always been identified. Accidents were recorded and analysed.

Staff recruitment was not robust. There were sufficient numbers of staff on duty to meet people's needs effectively.

Servicing and maintenance of the environment had been carried out in a timely manner.

Most training was completed but updates were needed. Staff were not clear about the principles of MCA and DOLS.

People were not supported to have maximum choice and control of their lives because staff had not supported them in the least restrictive way possible; the policies and systems in the service had not supported this practice. Staff had not followed the correct process for making the best interest decision.

People's nutritional needs had not been met and records in this area were poor.

Staff were clear about supporting people's privacy but they did not always maintain people's dignity. We saw some positive interactions with people.

Activities took place but they were not meaningful. This was being addressed.

The environment was dementia friendly particularly outdoors, but more signage would support people.

People knew how to make a complaint and we saw that where complaints had been made and there was a response which was in line with company policy. One complaint did not have a response recorded.

There had been a lack of effective oversight at the service which had led to a deterioration in the quality of the service. The quality assurance system had not been effective in identifying areas which required improvement.

End of life wishes had not been recorded for some people.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

People were not always protected from unsafe care.

There were sufficient staff on duty, both day and night, to safely meet people's needs but some staff had not been recruited safely.

Overall, medicines were managed safely but there were some areas of practice which needed to be improved.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff had did not always follow the principles of the Mental Capacity Act and had not always followed the required processes for consent to treatment and best interest decision making.

The environment did support people living with dementia but more could be done. Signage could be improved to aid people's independence when accessing areas of the unit.

People's nutritional needs were not met consistently which resulted in some people been put at risk.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

Feedback from people who used the service and relatives about staff was mostly positive but some people had less positive experiences.

Staff were clear about how they would support people's privacy but did not always promote their dignity. .

End of life documentation had not been completed in all cases which meant people's wishes had not been considered at this time.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans were not person centred and risks had not always been linked to the planned care and support.

Reviews had been completed but care plans did not always contain the correct information.

Activities were organised by a co-coordinator who worked each day. These were not aligned to people's interests at the moment.

Complaints were recorded and appropriate responses made.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

There was a registered manager at the service which is a condition of the registration for this location. People gave positive feedback about the registered manager.

There had been a lack of effective oversight of some areas of the service despite there being a quality monitoring system in place. There was a newly formed quality team but they had not yet carried out a monitoring visit at the service.

Record keeping was inconsistent which led to people being at risk.

# Bessingby Hall

**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 checked 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.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of choking . We were also informed by East Riding of Yorkshire safeguarding team about their concerns relating to a further three people who had now died. They had asked Humberside police to review these cases. This inspection did not examine the circumstances of the incidents.

However, the information shared with CQC (the Commission) about the incidents indicated potential concerns about how staff responded when people became unwell and their condition deteriorated. This inspection examined those risks.

This inspection took place on 26 October and 6 November 2017. The first day was unannounced and we made arrangements with the manager to return on the second day.

On the 26 October the inspection team consisted of one adult social care inspector, a bank inspector and two experts by experience. On 6 November 2017 an adult social care inspector and a specialist nurse advisor carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their expertise in this case was dementia and older people.

During the inspection we were provided with information by East Riding of Yorkshire Council about a safeguarding matter relating to one person and had discussions with them about other recent safeguarding concerns. We looked at all notifications we had received for the service. Statutory notifications are documents that the registered provider submits to the Commission to inform us of important events that

happen in the service. We had requested a PIR from this provider in 2015 which they had returned but we had not requested one since. 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 fifteen people who used the service. We also spoke with two relatives, a nurse, a team leader, two senior care workers, three care workers, a domestic, the activities co-ordinator, the registered manager, the regional manager, the operations director and one of the directors. We spoke with three visiting social workers and a doctor. 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.

We looked at how medicines were managed, observed activities and observed the lunch time period in the dining room, lounges and people's bedrooms. We reviewed seven care plans. We also reviewed quality monitoring records, servicing and maintenance records and other records relating to the running of the service. We inspected six recruitment records including the training records for these staff.

Following the inspection we spoke with a third relative. We asked the provider to send us an up to date statement of purpose and details of people who had a deprivation of liberty (DoLS) authorisation in place. DBS checks help employers make safer recruitment decisions and are designed to prevent unsuitable people from working with adults or children who may be vulnerable. These were sent to us in the week following the inspection.

Requires Improvement

# Is the service safe?

## Our findings

We inspected this service because of an incident that had occurred at the service which the provider had told us about. We informed East Riding of Yorkshire Council (ERYC) about the incident prior to the inspection and they requested that the provider complete an alert. These are called safeguarding alerts and are made to ERYC, because they have responsibility for investigating any matters relating to safeguarding adults in this area. There had been 16 safeguarding notifications made to CQC by the provider in the last twelve months.

The information we received from ERYC raised potential concerns about how staff managed risks to people's safety. ERYC staff had recently been visiting the service daily to review people's care and ensure people's welfare. In addition, any people receiving nursing services were being reviewed by community nursing staff. It was necessary for us to make two safeguarding referrals to ERYC following this inspection.

Appropriate safeguarding policies were in place for the service but they had not ensured that staff undertook the correct management of any allegations of abuse. Staff had received training in safeguarding adults as part of their induction and the care certificate. When we spoke with staff they were able to tell us that they would report any incidents to the manager or safeguarding team at ERYC. However, there was a lack of recognition when some people were at risk. The CQC inspector had to make alerts about two people to ERYC. This meant that some issues had not been identified as a risk by staff and some people were not safeguarded.

This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment.

When asked if they felt safe living at the service people told us, "I feel safe with staff" and, "Yes, staff check on me at night, and the building is safe." A relative told us, "Yes [relative] is safe; people are around her."

Risks to individuals had not always been adequately assessed and risk management plans were not always in place. There had been a recent choking incident at the service. When we entered one person's room we observed that a care worker was feeding them their evening meal. They were laid on their side with only one pillow. Their care plan said that they were at risk of choking. It is best practice to feed people in an upright position if they are at risk of choking. The same person had been identified with a Grade three pressure ulcer in their care plan but we read a letter from the nurse specialist saying that the pressure ulcer was Grade four. This meant people were at risk of avoidable harm because staff were not following the risk management plans for people and compromising people's safety.

One person's care plan identified that they were doubly incontinent and at high risk of skin damage and required positional changes every two hours. We saw that there had been ten occasions over three days (4,5,6 November 2017) when they had to wait up to five and a half hours to have their position and pad changed. In addition they had a weight loss recorded of 19.6kgs. Their records identified them as a low risk and no referral had been made to the dietician or GP. No actions relating to this weight loss had been recorded. The risk assessment used by the service stated that if a person lost more than 10% of their body weight in the last three to six months they should be categorised as a level 2 risk. This directed staff to refer

to a dietician or GP. These incidents were reported to the local authority safeguarding team.

One person's care plan said that they required 30 minute checks during the day and two hourly checks during the night. There were no checks recorded. The regional manager told us that no records were kept so we could not be sure that these checks had taken place.

The call bell system for the service could not be heard clearly throughout the service. If staff were upstairs they could not here the call bell alert. There was a sounder which lit up on the ground floor but if staff were working upstairs and did hear the bell they would have to go downstairs to check which room the call bell related to. This was not safe as staff were not always in range if people required assistance putting them at risk of harm. We did discuss the system with the provider who said they would look into ways of ensuring staff were aware of call bells ringing anywhere in the service.

Care workers could tell us how to protect people from the risk of cross infection and showed us they had access to protective aprons and gloves but their knowledge of infection control procedures was not always reflected in practice. The service was generally clean and washbasins were equipped with hand wash, soap dispensers and paper towels but some corridors and bedrooms smelled strongly of urine. A person in the dementia unit who stayed in their bedroom at all times had a wound. The soiled dressing had been left on a chest of drawers and there was no lidded bin or contaminated waste bag available in the bedroom. A wastepaper basket was available but was not lined with a plastic bag of any kind and had no lid. We asked carers how they disposed of continence pads which had been soiled and they said they would bring a bag into the bedroom, put the pad inside and then carry it to a yellow bin in a bathroom.

We saw there were no soft cleaning wipes available when the district nurse attended a person. Care workers said there were none in the store room and went to other areas of the home while the nurse and person waited. The care worker returned and said there were no wipes anywhere in the home and that a delivery was due. A second care worker told us supplies were delivered every three months and added, "We run out sometimes." This meant care workers did not always have the appropriate equipment available to support people with their personal hygiene.

A senior care worker reported this to the manager and we saw that within a short time a delivery of wipes arrived at the home. Meanwhile a care worker had found some personal wet-wipes and used those for another person who needed personal care.

Medicines were inspected in the nursing/ residential unit and the dementia unit. The provider used a bio-dose system which means each person's medicines were supplied by the pharmacy in sealed plastic containers for different times of day. In the nursing/residential unit we saw that medicines were administered safely. In the dementia unit we observed that staff practices when administering medicines varied. One senior care worker signed that medicines had been given before the person had taken them. In addition there was a discrepancy in the number of Paracetamol for one person; they had one too many. When the member of staff checked they realised that the discrepancy had occurred because this person had not received their tablet that morning but the medicine administration record had been signed. This highlighted why the practice of signing for medicines before they have been taken is not good practice. We carried out counts of four people's medicines and found other discrepancies. We fed this back to the provider who told us they would investigate these incidents.

One person told us they had medicines offered to them on two occasions which were not prescribed for them. They had capacity to know this. They refused to take them and later another member of staff confirmed to them that the nurse had confused them with someone else. We reported this to the registered

manager and operations manager who had been unaware of the incidents. They have started an investigation.

Controlled drugs (CD's) which are medicines that require extra checks and special storage arrangements because of their potential for misuse were stored safely. Access to them was restricted and the keys held securely. We checked medicines which required refrigeration and found they were correctly stored. Some people were prescribed topical medicines to be applied to the skin, for example creams and ointments. Topical MARs were in place to record the application of these medicines but were not always signed by staff to show the medicines had been applied.. Body maps were not in place to guide staff where to apply creams and topical MARs did not always contain this information.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Recruitment was not safe. We looked at six staff records and found that two people had started work prior to their disclosure and barring check (DBS) had been received. DBS checks provide information about people's background and help employers make safer recruitment decisions. They are designed to prevent unsuitable people from working with adults or children who may be vulnerable. One person had no employment history recorded, two people had gaps in their employment history which had not been explored and the manager was unable to produce records of discussions with one person about the details contained within their records. There was no risk assessment completed to determine whether this prospective employee was safe to work at the service. This meant that the provider was not meeting the schedule 3 requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014 to ensure that the staff they employed were safe to work at the service. This put people at risk of harm.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service had sufficient numbers of staff to meet people's needs. The dementia unit was staffed separately to the nursing and residential unit which gave a sense of consistency. One person told us, "Staff are rushed off their feet" but went on to say that they used their call bell at 8.30pm each night for a hot chocolate to be brought and it always was. Another person told us, "When I call them someone comes." A member of staff told us, "Staff numbers are fair." Our own observations showed that staff were not rushed and the service appeared calm. Call bells were answered promptly.

We made the registered provider and the management team aware of the concerns we had during the course of our inspection and at the end of the inspection during feedback.

Requires Improvement

# Is the service effective?

## Our findings

When we asked people if staff were skilled and knew what they were doing one person said, "Oh, yes, I am safer in the hoist than I am on my feet. They are good with me. "A second person told us, "Some haven't been trained properly, like when they are lifting me up the bed." We explored this comment further and the person told us that staff moved the mattress back on the bed and not them. However, we observed one person had accidentally fallen on to the floor. Staff responded with competence and patience when checking them for injuries and moving them off the floor using a hoist.

People had completed an induction which included completing three days training away from the service and then shadowing of more experienced staff. All staff had either completed the induction or had a date booked to attend. In addition staff completed training considered mandatory by the provider. This included moving and handling, dementia awareness safeguarding, infection control, health and safety and fire safety. In these subjects there was a high level of compliance with training but some training was out of date. For example thirteen people were not up to date with their safeguarding training although they had completed the training previously. There were 62 staff listed on the training matrix. Other training was available but not completed by all staff. The subjects included emergency first aid at work, food hygiene, end of life care and Mental Capacity Act 2005 and DoLS.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals 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.

People's plans of care showed the principles of the MCA had not always been followed. Consent to care and treatment records had not always been signed by people where they were able; if they were unable to sign a representative had not signed for them. For some people who lacked capacity, mental capacity assessments and best interest decisions had not been completed for their care and treatment. The MCA says a person's capacity must be assessed specifically in terms of their capacity to make a particular decision.

The service policy stated, "The home provides training on all aspects of mental capacity to improve their [staff] knowledge and develop skills in working with residents over their decision-making abilities." Staff were able to tell us about people when they may not have capacity to make complex decisions. They told us that everyone in the dementia unit could all make decisions about what food to eat, clothes to wear or what activities to take part in and we saw staff making sure people were given opportunities to make decisions.

They were able to describe best interest decisions and when restraint might be used to maintain the safety of a person. However, only twenty people had received some training in the subject and some of that training was not current. However, when we spoke with people they told us that staff asked for their permission before carrying out any personal care which demonstrated that staff were seeking consent but not recording this.

We recommend that the provider research the guidance for the Mental Capacity Act 2005.

Where appropriate, Do Not Attempt Cardio Pulmonary Resuscitation consent forms (DNACPR) were correctly completed with the relevant signatures.

People's nutritional needs were not fully met. Food charts recorded what people were eating each day but portion sizes were inconsistently documented. Fluid intake charts recorded the fluid a people were drinking but these were also inconsistently recorded. All charts were not fully completed and analysed, which showed staff were not effectively monitoring people's intake and taking action, as required where they were at risk of malnutrition or dehydration.

One person's nutrition care plan stated, "Staff to ensure adequate hydration; Two litres of fluid per 24 hours. Fluid intake must be calculated on the diet and fluid charts at approximately 12 midnight. We looked at their food and fluid charts and saw that their fluid intake did not reach the required amount over one week and on some days was not adequate. Food intake was not recorded or when it was, it did not record the exact amounts eaten on every occasion. There was no recording of intake from the early evening onwards.

People's weights had been monitored but on some occasions where weight loss was noted there had been no action.

We observed lunch time in both dining rooms. Care workers supported people who needed help to eat and drink and took food to and supported the people who stayed in their rooms. A relative sat at one table with their partner and care workers sat talking with some people to eat and drink. Three days a week lunch was served in a lunchbox in the dementia unit. The lunch box had a lid placed on so people could take it outside or eat later with their fingers. However, this did mean that people living with dementia took their boxes to other areas and were not always supervised by staff when eating. One person preferred a plate and care workers knew their preference and served their food on a plate. One lunchbox contained sandwiches, a scotch egg, chicken nuggets and some grapes, pre-sliced lengthways. People appeared to enjoy the food. Textured diets were provided for some people who had trouble with swallowing.

During lunch a care worker went around the tables and asked people what they wanted to eat the following day. Talking about food that was not available until the following day might have been confusing for people living with dementia or they may forget what was offered.

Records did not include notifications to the kitchen regarding food likes, dislikes and dietary needs. This meant there may not be good communication between care and catering staff to support people's nutritional well-being.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The dementia unit environment supported the needs of people living with dementia to some degree. There was a colour contrasting handrail and use of colour to identify important places such as the toilets. Bedroom doors and corridor walls were not distinguishable from each other for people with visual or

cognitive impairment. There were very few customised signs to identify the person's room using names and photographs or personal objects. This was not helpful in retaining people's independence in finding their own way around the building. The lounge / dining area had two doors, one had a sign that said 'Conservatory' and the other had no sign at all which could have been confusing for people. The dementia unit had spacious communal areas but some bedrooms were in corridors that came to a dead end.

The unit had developed a garden which could be accessed freely from the dining area. This was enclosed with level access ensuring everyone was able to gain access. There was a greenhouse and raised beds which people were able to use to help maintain supporting their wellbeing. Relatives also helped to maintain this area.

People's healthcare needs were met by their GP and from other health professionals including nurses, dietician, speech and language, dentist, optician and chiropodist. Everyone we spoke with told us that apart from their GP no other health professionals were involved in their care.  One person told us, "If you want a doctor the nurse will get one. The chiropodist visits me every 6 weeks." A relative said, "My [relative] has booked for a check up with the doctor." We saw from people's records that other professionals had been involved in their care. However, we determined through our inspection of records and talking to people that some people were not always referred to the appropriate healthcare professionals in a timely manner which meant the nursing care they experienced was not always in line with appropriate guidance and increased the chances of people having poor outcomes.

Requires Improvement

# Is the service caring?

## Our findings

People's comments about staff were varied. Their comments included, "The staff are a lovely lot"; "They are all very good"; "Good, can't complain - they sit and chat"; "All very nice; helpful"; "Some staff are a bit abrupt; others are ok" and "Staff vary, some will do more." One relative told us, "Staff are fine with me" and another said, "Staff are lovely particularly the domestic staff who always have a chat with you."

Throughout the inspection we observed care workers interact with people living in the home in a pleasant and cheerful way. They called people by name and used humour appropriately. When care workers spoke to us about people they cared for, they did this in a caring and affectionate way. One care worker talked about a person who was described as, "Usually cheerful and liked to keep busy." They told us about the person's history and how they supported them. They understood the person's behaviour changed when they felt afraid or threatened and knew how to help them avoid situations that might trigger such behaviour.

A care worker said they would want their relative live in Bessingby Hall because, "We treat people like our own family." Another care worker told us, "People living here may have dementia but they pick up on our feelings" and described how a person had patted their hand and asked what was wrong when they had been upset one day. These incidents created bonds between people.

Care workers discussed how they helped people maintain independence for as long as possible and how getting to know people well helped them know when to help a person and when to let them do things themselves, even if they were slow. Care workers said they asked people if they had preferences about personal care being delivered by male or female carers but we did not see those preferences recorded. They said they protected people's privacy and dignity by knocking on bedroom doors before entering and keeping doors closed when delivering personal care.

People's privacy was respected. We observed people knocking on doors before entering rooms. However, people's dignity was not always maintained. We saw at mealtimes that people were not offered clothes protectors resulting in spilled food for some people. They were given small paper napkins which did not provide the support some people needed. We saw one person with food spillage on their clothing earlier in the day which was not changed by staff. On the whole however, we saw that most people's dress and footwear was appropriate.

Care in the dementia unit was delivered in a caring way by staff who empathised with and valued people. However, one person in the residential nursing unit told us, "I only see staff when they come to change me."

Some people had personalised their rooms and one person told us, "I have all my things in there and my memories."

People's families were made welcome and offered drinks when they visited. Relatives were encouraged to participate in the life of the service particularly in the dementia unit. One person told us, "I think my family come to see me and I'm sure they get a cuppa." A visitor told us, "They make me feel welcome. They can't do

enough for us."

People were not always supported to express their views. We saw that several people had completed feedback forms but it was not clear when this was. The themes from those questionnaires were that people were not always supported in their decisions and choices. One person had said in their response when asked is staff listened to what they wanted, "Not all the time." Only one person could tell us about residents meetings despite there being a meeting only the day before. One person said, "I can't get to meetings and have never been asked" and another said, "We had a meeting yesterday. We were told Chef was leaving so we said goodbye; they tell us what is happening."

We saw in two people's care records that end of life care plans were not in place, which meant information was not available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected.

Requires Improvement

# Is the service responsive?

## Our findings

Care planning documentation was not always person centred and people were not always involved in their care planning. When we spoke with a visiting doctor they told us, "The staff are very helpful. They have the relevant paper work ready for me when I come in and there is always a member of staff free to talk if I have any questions.

We saw that the manager had researched good practice in dementia care and staff were asked to change into suitable night wear in the evening to assist people living with dementia in recognising that bedtime was approaching. The manager told us they had seen a reduction in distressed behaviour at bedtime and people were settling into regular sleep patterns following this initiative. We saw the research that had prompted the change which identified that this was beneficial in the care of people with dementia.

However, there were inconsistencies in people's treatment. Wound treatment and care plans were not completed in detail in all cases which meant staff may not respond appropriately to people's needs. One person had a wound treatment plan which was clear, detailed and evidenced the description of the wound, the progress which was being made, together with observations to be made should the wound deteriorate. There was documented evidence of access to the Tissue Viability Nurse to assess people's skin condition and provide specialist support on what was needed in terms of care and pressure relieving equipment, to minimise the risk. However although another person's treatment plan was clear, the wound chart did not consistently detail and evidence the description of the wound, the progress which was being made, together with observations to be made should the wound deteriorate. This meant that there was no clarity about changes to the wound. In addition staff had identified one person as having a Grade 3 pressure ulcer when the tissue viability nurse had identified it as Grade 4 which meant that staff may not be providing the correct response to this persons care.

One person was diagnosed with diabetes. There was no specific risk assessment evident although there was instructions for staff about how to manage changes in the person's condition within the care plan. Within the diabetes care plan we saw that the person's dietary requirements were included, however associated health checks were not included.

We spoke with a visiting social worker who told us, "I have been two or three times since September 2017 and saw that referral to the Occupational Therapist and dietician had been recommended for one person. The home didn't contact them as they thought they didn't need an OT and dietician; it's all done now."

During the morning meeting on the 6 November 2017 we heard that one person was not drinking and was becoming dehydrated. The manager suggested that they could be moved to the nursing area and fluids be given subcutaneously. The service is currently suspended from providing nursing provision for any new people admitted to the service by ERYC. This means that people who are currently receiving nursing care at Bessingby Hall will continue to do so but the provider will not accept anyone into the service with nursing needs until the suspension is lifted. The inspector discussed this with the manager reminding them of this and suggested they ring the person's GP instead.

One relative did tell us, "They can't do enough for us. They have organised a new wheelchair for my husband and that will be so much better for him." However, we found that the staff response to people's care was inconsistent.

There was a newly employed activity co-ordinator. They told us they had only been in the role for six weeks and had no specific training. We did observe that they were adept at bringing people together and people responded to them. They arrange activities such as gentle keep fit, dominoes, magnetic darts and bingo but told us they are still finding out what people want. They walked with some people into the village. They did not keep activity records but recorded activities in people's care records. The record said whether or not they had enjoyed the activity.

People's feedback about activities was varied. Their comments included, "I play darts, dominoes and sit and watch the TV; I would be lost without it"; "I play dominoes, watch TV and I go to the church service here"; "The activity co-ordinator came and played dominoes with me. My son visits too" and, "None, by choice." A relative told us, "They did offer her activities but she doesn't want any, she gets lots of visitors." Activities were not planned in line with people's interests.

In the dementia unit one person started to get upset and wanted to go home. The activities assistant took him for a walk to his room and he came back with a hand full of photos of his home, his dogs and pictures relating to his previous life. They calmed down and sat chatting.

In the afternoon people in the unit prepared pumpkins for Halloween. The staff put some different coloured paints on plates and some brushes. One gentleman was able to scoop out the pumpkin and others painted.

People knew how to raise concerns or complaints. There were three recorded complaints with appropriate responses in two cases. A third complaint had no response attached. People told us they would complain to a member of staff or the manager. One person said, "I asked for a bed control (to adjust sitting position) and I got it. The manager sorted it." Another person said, "I would tell my family and they would sort it." A relative told us, "I go to reception and they sort things for me."

Requires Improvement

# Is the service well-led?

## Our findings

Bessingby Hall is one of thirteen services run by Burlington Care Limited. It was previously rated as Good.

There was a registered manager employed at this service who had been there for over one year.

They were supported by a newly appointed regional manager who was overseeing the service and was present for the inspection. There was also an operations director who came to the service on both days of the inspection. There had been a lot of recent changes within the management team.

Feedback from people was varied but generally spoke highly of the manager saying that they were approachable and that they listened. The atmosphere of the home was very relaxed and homely. Staff were friendly. People told us, "It seems to be okay"; "As far as I know [it is well managed]." A relative said, "It seems to be. The manager is very nice but it is frustrating because some things do not get done."

There had been a high number of safeguarding alerts made to the local authority in the last year and the manager had been working with the local authority and other professionals to make improvements at the service.

Generally staff felt supported. However they did not always recognise their roles and responsibilities which had resulted in some people not receiving care and attention in a timely manner. Some people had been identified by the safeguarding team over the last year as having had to wait for medical attention which had resulted in them suffering pain and distress. These cases are the subject of a separate investigation and as such have not been discussed in this report.

There was a quality assurance system in place but a lot of the issues we raised had not been identified in audits completed by the service. For example the recent environmental audit had not identified areas of concern highlighted by the inspection team. The registered provider and managers had not been thorough in their oversight of the service and this had led to some audits which were not robust. This had resulted in a situation where the basic care of some people was not of a high standard and had placed them at risk.

Record keeping was not consistently applied and there was missing information on turn and food and fluid charts

Accidents and incidents were being recorded in both daily notes and in a central monitoring system. Although we saw that the incidents were analysed and trends identified we did not see any actions to prevent reoccurrence.

The provider was not making sure that correct processes were followed diligently by staff resulting in risk to people. For example, the manager had implemented food and fluid charts but staff had not completed them in detail which did not provide a clear picture of people's current situation.

Risks to people's health, safety had not always been acted upon. For example, one person's care was not being well managed by staff but no advice or support had been sought by managers. No request for a reassessment of the person's needs had been requested by the manager.

Notifications to CQC had not always been detailed which meant that the inspector was unaware of some risks until informed by ERYC.
The registered provider had failed to ensure that they were meeting all the Regulations.

This was a breach of Regulation 17 of the Health and Social Care act 2008 (Regulated Activities) 2014 Good Governance

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Care and treatment was not provided in a safe way for service users. The provider had not.assessed the risks to the health and safety of service users receiving the care or treatment or done all all that is reasonably practicable to mitigate any such risks. |

**The enforcement action we took:**

Issued NOD Urgent provider condition to suspend admissions
NOP to vary condition and remove nursing

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Service users were not always protected from abuse and improper treatment. |

**The enforcement action we took:**

Issued NOD Urgent provider condition to suspend admissions
NOP to vary condition and remove nursing

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The nutritional and hydration needs of service users were not always met. |

**The enforcement action we took:**

Issued NOD Urgent provider condition to suspend admissions
NOP to vary condition and remove nursing

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 17 HSCA RA Regulations 2014 Good |

| | |
|---|---|
| personal care<br><br>Treatment of disease, disorder or injury | governance<br><br>Systems or processes were not operated effectively to assess, monitor and improve the quality and safety of the services provided. They did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;<br>They did not evaluate and improve their practice. |

**The enforcement action we took:**

Issued NOD Urgent provider condition to suspend admissions
NOP to vary condition and remove nursing

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Recruitment practices were not established and operated effectively to ensure persons employed for the purposes of carrying on a regulated activity were of good character and had the qualifications, competence, skills and experience which are necessary for the work to be performed by them. |

**The enforcement action we took:**

Issued NOD Urgent provider condition to suspend admissions
NOP to vary condition and remove nursing