Millcroft & York Lodge Care Homes Limited

York Lodge

Inspection report

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Ratings

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

Overall summary

We inspected York Lodge Care Home for the Elderly on 13 and 14 July 2015 and the inspection was unannounced.

York Lodge is located in Crowborough and provides accommodation and personal care for up to 22 older people. The home is set out over three floors and a basement. There is lift access between the ground floor and upper levels. At the time of our inspection there were 21 people living at the home. Everybody living at York Lodge was living with dementia and many people had mobility and sensory challenges.

The home had a registered manager. 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.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of this report.

People said they felt safe living in the home however we found that not all risks had been identified or effectively managed.

Summary of findings

People were not protected from the risk of the spread of infection with laundry in shared bathrooms and décor and furnishings that made effective cleaning difficult.

The provider followed safe recruitment procedures to ensure staff working with people were, as far as possible, suitable for their roles. However, staffing levels were not based on people's needs and did not promote their safety and wellbeing.

The registered provider had not ensured that people received their medicines according to their needs.

Staff did not have the necessary skills and knowledge to ensure they could meet people's complex needs. Staff had not received the training they needed to enable them to carry out their roles effectively.

Assessments of people's capacity to make decisions had not always been carried out in line with the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Meal times did not take account of individuals' needs and people did not receive the support they required.

People received medical assistance from healthcare professionals including district nurses, GPs, chiropodists and the local hospice.

The premises and equipment did not meet the needs of people living with dementia and mobility challenges. We identified a number of maintenance issues that impacted on people's wellbeing.

Staff were sometimes task-orientated and did not show kindness or compassion in their approach. Staff did not always listen to people or treat them with respect.

Staff did not always respond or know how to respond, to people's distress. People's communication needs were not respected or enabled.

People's needs were not consistently met as assessment and care planning was not always effective. People's changing needs were not consistently responded to. We observed that the people who required the most care and support were not always given the support they needed to ensure they had meaningful occupation during the day.

People were supported to maintain their relationships with people that mattered to them. Visitors were welcomed and their involvement encouraged.

People and relatives felt the home was well run and were confident they could raise concerns if they had any. However, there were not robust systems in place to assess quality and safety. The registered provider had not adequately monitored the service to ensure it was safe and had not identified or acted upon areas where improvement was required.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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?

Inadequate

The service was not safe.

People were at risk of harm because not all risks had been identified or effectively managed.

People were not protected from the risk of the spread of infection in the service and the home was not maintained, cleaned and equipped to an appropriate standard.

There were not sufficient staffing levels to safeguard the health, safety and wellbeing of people.

The registered provider had not ensured that people received their medicines according to their needs.

Is the service effective?

Inadequate

The service was not consistently effective.

People did not receive effective care from staff who had the necessary skills training and knowledge to meet their needs.

People were not protected from undue restriction as staff and management had not consistently followed the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Meal times did not take account of individuals' needs and people did not receive the support they required. People were at risk from the dangers associated with poor nutrition as did not receive the support they needed.

People received medical assistance from healthcare professionals when they needed it.

The provider had not ensured the premises were suitable for people living with dementia and mobility challenges.

Is the service caring?

Requires improvement

The service was not consistently caring.

People were not consistently treated with compassion.

People were not consistently treated with dignity and respect.

People's communication needs were not effectively supported.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not consistently met as assessment and care planning was not always effective.

Summary of findings

People did not always receive personalised responsive care that met their needs.

People with mobility difficulties were at risk of becoming socially isolated with little activity to stimulate or interest them.

People knew how to make a complaint and were given opportunities to give their views. Relatives told us they were kept informed by the home.

Is the service well-led?

Inadequate 

The service was not consistently well led.

The provider had not ensured that there were systems and leadership in place to effectively monitor the culture, quality and safety of the services provided.

There was an open culture. Staff felt supported and were confident that they could discuss concerns. People who used the service and their relatives felt the staff and manager were approachable.

York Lodge

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 took place on 13 and 14 July 2015 and was unannounced.

The inspection team consisted of two Inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using, or caring for someone who uses this type of service.

Before the visit we looked at whether we had received any notifications. A notification is information about important events which the home is required to send us by law. We also spoke with the Local Authority.

We spoke with seven people and six relatives about their experiences of using the home. We also spoke with the registered manager, deputy manager, service manager, five care staff, three members of maintenance and housekeeping staff and two health professionals. We examined records which included seven people's individual care records, four staff files, staff rotas and staff training records. We sampled policies and procedures and the quality monitoring documents for the service. We looked around the premises and spent time observing the support provided to people within communal areas of the service.

Inadequate

Is the service safe?

Our findings

People told us they felt safe and assured that staff did everything possible to protect them from harm. "Oh golly yes, I feel it is home" and "Yes, I'm quite happy." Relatives said they could go home feeling relaxed and knowing their family member was safely cared for, "Yes, X is safe and well cared for." Another relative told us, "She can't get out and she would try and get out and wander, so I am pleased she can't get out."

Although people told us they felt safe, we found that the systems to protect people from harm were inconsistent.

A fire risk assessment had been undertaken by an external consultant in June 2015 which had identified a number of hazards that the maintenance team were prioritising and said would be completed within a month. However everyone in the home was living with dementia and many people had mobility and sensory needs, but risk management strategies were not consistently in place. For example we looked at the "Residents Fire List" dated 29 June 2015, a copy of which had been sent to the local fire safety department. This list described people's mobility in the event of evacuation. However it gave inaccurate information and stated that four people were mobile when their care plan confirmed they required two staff to assist them, using a hoist. This meant people were at risk, as staff did not have the information they needed to make sure they would be able to help them safely in an emergency.

The management of risks was inconsistent. For example the home had environmental risk assessments for particular areas within the building. However our inspection identified risks that the provider had failed to identify. For example, the home had two stair cases leading to the upper floors and we were told by relatives and staff that these were regularly used by people. However on both stair cases there were areas where handrails were missing which put people at greater risk of falling. One staff member told us "It's not appropriate because of the kind of residents we have. The stairs are very risky to them."

Relatives and staff told us that as people were living with dementia it was important the building was secure. However, on the second day of our inspection, we found that the door from the TV room was left unlocked with the door alarm turned off. The door led to a raised patio area that had some uneven patio slabs and steps leading down to the garden. As the door closed back, we found there was no means of opening the door to get back in. This meant that anyone outside would find themselves unable to get back inside and as the alarm was not turned on, the staff would not have known if someone had left. We pointed this out to the management team who were unaware that the door alarm had been turned off.

Not all people were protected from the risk of harm because risks were not managed consistently This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staff were able to tell us which people were at risk of experiencing falls and how they used appropriate equipment and ensured that items of furniture were not in people's way. Care plans contained information which assessed people's risk of falling and some guidelines regarding the support they required to be mobile. We identified that seven out of the 22 people living at York Lodge required the use of a hoist; however, the home only had one full hoist and one standing hoist that the manager said was rarely used. Care plans gave no guidelines as to which slings people required. The registered manager told us that people shared slings and that the home kept one small, one medium and one large sling for transfers, as well as two for personal care. There were no spare slings when a particular sized sling became soiled and required washing. This meant people may be put at risk of infection or of an unsafe transfer. Personal emergency evacuation plans stated that eight people required use of a wheelchair, however, staff told us ""We don't have enough wheelchairs, we only have two." The provider had not ensured the home had the right equipment to meet people's needs.

During our inspection we found a number of issues that required maintenance; a broken toilet door lock, a shower door broken, a bath out of use with a broken chair lift, holes in plasterwork, damaged paintwork, a large number of tiles missing beside a toilet and bare plasterboard in a person's bathroom. Staff told us, "It would be nice to have it refurbished." Although the registered manager showed us quotes they had secured for refurbishing the top floor bathroom, records showed that the bathroom had been left in in poor condition for a number of months and had yet to be refurbished. One staff member told us, "I wouldn't like it if it were my home, it's not a nice atmosphere to be bathed and toileted in."

Inadequate

Is the service safe?

During our inspection we identified risks in each of the three shared bathrooms. On both inspection days we observed that soiled laundry was left stored and exposed. In one bathroom, laundry was overflowing from the laundry bins resulting in soiled and non-soiled laundry having become mixed. The toilet brush in the top floor bathroom was soiled and unhygienic. We pointed this out to a member of care staff who said that they had reported it but it had not been changed.

In the ground floor bathroom there was a domestic pedal bin marked "Clinical Waste" and the registered manager told us this was used for dressings and sharps. When the inspector told the registered manager this presented a risk to people, it was removed. The shower surround in the first floor bathroom was made of marine plywood. This was unsuitable for a wet area as it was not possible to clean it effectively. The shower tray in this room was soiled. The ground floor bathroom was carpeted and we observed marks on the carpet around/near the toilet. Having carpet in an area where soiling was likely to occur or where it was likely to get wet meant there was an increased risk of infection and meant this area could not be kept clean effectively. We looked at the cleaning schedule and it was incomplete. A member of the housekeeping staff told us that there was a daily cleaning schedule but that staff did not always have time to complete it. We spoke with the service manager and they were unable to find a record that showed that the bathroom carpet was regularly shampooed and cleaned.

The lack of an effective system to ensure the home was maintained, cleaned and equipped to an appropriate standard was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We raised these issues with the registered manager and on our second day a number of repairs were underway. Laundry was removed from shared bathrooms and new flooring was being ordered for the downstairs bathroom.

Relatives told us, "Yes, there's enough staff - there's been a couple of lean spells lately, two to three staff moved on so there's been agency, but they're very good." Another said, "Sometimes it feels short staffed." One staff member told us, "Our biggest challenge here at York Lodge is staffing- if there was enough staff we would be able to give good quality time and care to people." We found there were times when staff could not provide all the care people needed. One relative told us that they had recently been asked to accompany their relative to hospital in an ambulance as the home did not have enough staff on duty to allow a staff member to go.

The rota showed that there was frequent use of agency staff on a planned basis. The registered manager acknowledged that staffing levels were inadequate and told us they had struggled to recruit and had therefore been using agency staff to fill vacancies and cover sickness. Permanent staff told us that they found this a strain because the agency staff did not know the residents and needed supervision by permanent staff. One relative told us, "There's not an enormous number of staff, there's been a lot of turnover in the last two years, and agency staff do their best."

We found that staffing levels were not based on an analysis of people's support needs. The deputy manager told us that she spent time providing care at the expense of her managerial duties to make sure that people's needs were met. One staff member told us, "There aren't enough staff for the complex needs that are here and, "They don't get any one to one time other than when they are getting their basic needs met." All residents lived with dementia and many had poor mobility and required support with personal care and eating. Staff told us that they were often busy and under pressure. One staff member told us "There are times we are really short, when we are doing caring, medication and kitchen duties." We found that where there were insufficient numbers of staff, there were times when people did not receive the support they needed. For example, during lunchtime we heard one person quietly and persistently call for help, "Somebody help me- don't forget me." This person remained unsupported until an inspector asked staff to assist. Another person pushed their food away and then moved their chair back without eating. We heard the person call "I don't know where I am here" and "Is there somebody there who will help me?" It was some time before a staff member noticed and moved them closer and only once did we observe a member of staff provide reassurance and explanation telling them, "You're in the dining room having lunch."

This failure to ensure that there were sufficient numbers of staff deployed to safeguard the health, safety and welfare of people was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

We observed the senior carer administer medicines to people. They wore a red bib to indicate they were not to be interrupted and asked that they should not be disturbed during the medicines round. We observed them as they explained to people what their medicine was and what it was for. We saw that medicines were stored appropriately in a locked trolley and a locked refrigerator in an air-conditioned room. The room and refrigerator temperatures were checked and recorded twice daily. We saw that staff had recorded the date on which bottles of medicine in solution and eye drops had been opened so they remained fit safe for use. Staff who gave out medication had received training to do so. Two members of staff were due to have their training refreshed but this training had not yet been arranged. The manager had recently commenced a programme of assessing staff members' competency to give out medication.

There was a medication policy that included guidance for covert administration of medicines, self-medication, drug errors and adverse reactions. However there was no policy for giving medications, such as pain killers that were prescribed to be given "as required". As many people had difficulty communicating, the manager told us that staff used their judgement based on people's body language and facial expressions to determine whether they required painkilling medication.

During the medication round we observed a carer trying to give medication in tablet form to one resident who appeared to be having difficulty swallowing. The carer told us that the home was trying to obtain the person's medication in solution form. When we checked the person's records we saw a note from three months earlier that said medications should be changed to solution form where available. The person's most recent nutrition and hydration care plan did not make any reference to the difficulties they experienced in swallowing. The manager undertook regular audits of medication. These audits identified failings such as drug omissions or dosage errors and we saw that actions were taken to help prevent their recurrence.

The registered provider had not ensured that people received their medicines according to their needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staff we spoke to were aware of their responsibilities to safeguard the needs of residents in their care. They had a good understanding of the signs of abuse and were familiar with the actions they had to take to report suspected abuse. Staff told us they were confident that the manager of the home would take action to deal with any abuse that occurred

We looked at four staff recruitment files and found they included a completed application with previous work history, qualifications and experience of the person applying for the job. References and criminal record checks were also included. This meant that the Provider had taken action to ensure that permanent staff were as far as possible, both suitable and safe to work with people living at York Lodge. Staff who had been recently appointed described the process for their recruitment including the appropriate screening checks.

Inadequate

Is the service effective?

Our findings

People who were able to tell us about their experiences said they were happy with the care they received and one person told us, "They're all very kind and helpful, I've no complaints";

Relatives said, "Staff are excellent, I honestly think (x) couldn't be in a better place" and, "They do their best given her condition."

One relative said they felt that new staff and agency staff were sometimes not experienced enough and they told us, "A handful of girls left, they were the core, they had a different attitude." We found that new staff had undergone an induction which involved shadowing more experienced staff. We saw that the staff training plan recorded mandatory training but there were gaps in some areas. One member of staff, who had started in April, was yet to complete moving and handling, first aid or safeguarding training. Five out of eleven care staff had not undertaken training in infection control and three had not undertaken training in food hygiene. During our inspection we found issues with both. For example, the home had assessed the risk of food poisoning and the assessment stated that food leftovers were to be discarded after two days and that food, opened bottles and jars should all be dated when opened. However, we found food in fridges that had not been labelled with a date of opening and some that that had not been disposed of despite being opened in August 2014. Not all staff had the skills and knowledge to deliver safe or effective care.

The statement of purpose said, "The speciality is with dementia residents" and everyone living at York Lodge was living with dementia. However only ten out of nineteen staff had completed dementia training. The deputy manager had not undertaken training in the care of people with dementia and was instead working her way through a booklet of learning materials that had been made available to her. The deputy manager had begun to undertake assessments of staff members' competency at giving medication and at carrying out correct hand washing technique. However, the deputy manager had not received any training, or herself been assessed as competent in assessing other people's competency. We saw records that showed the registered manager had signed off competencies for some new staff, however they were unable to show us any records of on-going checks. We looked at staff questionnaires recently completed. When asked what training was needed, one staff member said dementia training. Another said they required training to write care plans and two others said "I need to learn more about my work." Where there were gaps in staff's current training, the manager was unable to show that this training had been scheduled. This meant the provider had not ensured that staff had the skills and knowledge required to meet the needs of people living at York Lodge.

We saw records that staff had received occasional supervision with their line manager. However the registered manager showed us a copy of their supervision schedule which stated that, "Supervision to take place 12 times per year." We also looked at the home's own supervision policy which stated supervision was to "Take place every 6 to 8 weeks." Records showed that whilst staff had received supervision it was not in line with either frequency.

Staff had not consistently received the training and support they needed to carry out their roles and deliver effective care. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We observed some staff asking people what they wanted and waiting for their responses before they cared for them. This showed staff did seek people's consent or at least sought their opinion prior to delivering care. We saw that some people's care plans contained a 'Do Not Attempt Cardiac Pulmonary Resuscitation' order. This had been correctly completed after consultation with the person and their family and signed by their G.P. However we found that these had not been reviewed to show they remained the current wishes of the person, their legal representative or the GP.

Some care plans we saw contained a mental capacity assessment. However these were generic and not specific to the decisions people were making. When we spoke to staff, they were aware of the need to assess mental capacity specifically in relation to each decision being made.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. This legislation sets out how to proceed when people do not have capacity and what guidelines must be followed to ensure people's freedoms are not restricted. It provides a process by which a person

can be deprived of their liberty when they do not have capacity to make certain decisions and there is no other way to look after the person safely. The management had submitted some DoLS applications and were awaiting the local authority's authorisation. The manager told us that they were prioritising those people who would attempt to leave the building and therefore had not completed mental capacity assessments and DoLS applications for people who had other restrictions such as bed rails.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were not always complied with. Assessments of people's capacity to make decisions, had not always been carried out in line with the 2005 Act. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home used a company to provide pre-made frozen meals that were heated up by care staff. People told us they enjoyed the food, "Yes, it's very good, always a choice. We laugh if it's not so good" and "There's lovely sweet dishes."

One relative told us they were "A bit disappointed by the food as it is bought in and the portions are small." Another told us, "It's basic but good." During lunchtime we found that a number of people required support with eating and drinking. Although people were sitting waiting from 12.30pm, lunch did not start to be served until 1pm. As care staff were also responsible for heating and serving food, we observed that some people waited longer and there was no one to reassure people or observe when people became restless. One member of staff told us, "Mealtimes is a struggle. You can't rush people and they need support and so people are left waiting." We observed that people did not all eat at the same time and that some people were still being served at 1.20pm by which time others had finished their lunch and had to wait a long time for their dessert and cup of tea. We saw that people who were independent were served first. This meant people with more complex needs were left waiting and at times became confused and restless. For example, one person who had spent the morning in their room, came down for their lunch. They sat at one of the small tables but after waiting a while with no drink, food or explanation given, they got up and left. Two staff members offering one to one support elsewhere were not seated in a position to be able to see the person leave. It was only after a member of the inspection team alerted staff that the person was supported back to the table where they sat and waited again for their lunch. Once their meal had been served, another person became restless and distressed which prompted the person to leave the room again.

One person was given a plate guard to encourage their independence and was reminded "Don't use bare hands please." However, as there was insufficient support and observation, the person began to use their hands and most of their food was pushed off the plate and onto the tablecloth and floor. We heard other people shout out, "X is eating with their fingers!" There were insufficient staff to ensure people received their meals in a timely and dignified way.

Staff told us that they were fortifying foods for some people to provide additional calories and that one person had been referred for speech and language therapy (SALT). We saw that care plans included nutritional risk assessments. However we found that these were not always adhered to. One person's risk assessment said, "(X)'s swallowing ability seems fine at the moment, staff will monitor and report any changes." However their nutritional care plan noted that they had been referred to the Speech and Language Therapy Team (SALT) due to swallowing difficulties and weight loss. Despite on-going eating difficulties, this person's weight had not been regularly monitored since 04 May 2015.The SALT advised this person was at "High risk of aspiration or choking on oral intake." and recommended foods that would minimise this risk. However, the record that listed people's dietary requirements described this person's diet as "normal".

We looked at records of other people's weight and found that this was not being monitored as frequently or regularly as was written in their care plans. For example one person's nutrition and hydration plan called for weekly weight monitoring, however their records showed that this had not been done for eight weeks. Another person also requiring weekly monitoring had not been weighed for seven weeks and their nutritional assessment that required monthly updating had not been completed since April 2015.

People were nutritionally at risk as they did not receive the support they needed to have enough suitable food to eat and drink. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014

Inadequate

Is the service effective?

York Lodge is an extended period property with bedrooms and bathroom facilities positioned over three floors. We observed that where people were living with dementia, mobility difficulties and sensory impairments the design did not aid their independence and navigation. We found that corridors were long and people's rooms were not all identifiable. Some areas, including a staircase had patterned carpet. The service manager told us they were aware that this could prove difficult for people living with dementia and had previously replaced this carpet in other areas of the home. We found that the communal shower was positioned in such a way that access was difficult as there was not sufficient space to get to it if using a mobility aid or wheelchair. One staff member told us, "Bathrooms are very cramped" and another said, "Moving hoists and wheelchairs around is a nightmare, there is no space."

The largest brightest area with views of the garden was the conservatory but staff told us that this was rarely used as was too hot in summer and too cold in winter. One staff member told us "The conservatory is not used, only for relatives." Another said, "I don't know why we don't use the conservatory." As a result people were sitting either at dining tables or in smaller lounge areas off the dining room. We saw that space in the dining room and small lounges was limited. For example, there was not enough room for everyone to sit at a table should they want to. Tables were arranged together as one large table that seated six people while smaller tables were only partially accessible and therefore not suitable should all residents wish to eat at a table. In the small lounge areas off the dining room, there were twelve comfortable chairs, the majority of which had their backs to the garden views. The other comfortable chairs were in the unused conservatory. As a result this meant that many people sat for long periods of time on dining chairs at tables, as there were not enough comfortable chairs in the lounge for everyone to use.

The registered provider had not assessed the environment to ensure it met the diverse needs of people. Consideration had not been given to relevant guidance about dementia friendly environments to help people safely find their way around. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans included information regarding their health needs. We saw from people's records that they were able to access services such as chiropody, ophthalmic and dental care. One relative told us, "If there is anything wrong they are fantastic and they get the GP." Where a resident had recently been acutely ill we saw that staff in the home had recorded this and ensured that the person attended the accident and emergency department. On the day of our inspection one person attended hospital for a scan and we also saw that a GP was visiting.

Requires improvement

Is the service caring?

Our findings

People told us that staff were kind, caring and attentive. One person said, "Oh they're very caring" and, "They're all very kind and helpful, I've no complaints." Relatives told us, "I like the way they treat people, they treat people as human beings," and, "They've all got caring traits, some are more outgoing than others."

We observed some staff being courteous and respectful, for example, knocking on people's doors and then waiting and asking for people's consent before helping with care. We observed that some staff treated people kindly using humour and gentle reassurance when needed. One member of staff was holding a person's hand whilst singing along to music. Another member of staff supported a person to drink their morning tea, dipping the biscuit into the tea before gently putting it to their lips and carefully wiping their mouth with a tissue. However, this approach was not consistently used by all staff.

One member of staff discussed intimate personal details regarding a person's needs whilst in the hall way in front of other people. The member of staff did not attempt to hold this conversation in a quietened voice or out of earshot of other people. This meant people's confidentiality was not always respected.

Nine people ate their meals in armchairs that they remained in throughout the day and that were mostly positioned side by side in a row. One relative told us, "They feed her, they've nice big serviette bibs but they don't use them. She's got stuff dribbled down her top. If they put a serviette up, they'd catch all that." One member of staff was sitting in front of two people without smiling or chatting whilst spooning food to each person alternately. This approach did not demonstrate respect or treat people as individuals.

During lunchtime one member of staff positioned a dessert in front of a person, without explaining or smiling. The person sitting next to them asked for their dessert and the staff member responded brusquely and told them, "It's coming (X)." The member of staff then took the dessert away and gave it to the other person without explanation or reassurance. At one point we observed this member of staff sit in front of these two people with their back to them making no acknowledgement that they were there. Later we observed the person drop their dessert in their lap and the person sitting next to them called for staff assistance but was ignored. When we asked a staff member to assist, we saw that they grabbed the persons spoon and took it away, leaving the person with their dessert still in their lap. When the person sitting next to them tried to explain, the staff member was again brusque and told him, "I am already assisting her." This showed that some staff did not communicate in a way that was respectful, dignified or pleasant.

During lunchtimes one person was in an armchair eating their meal. We saw that staff had positioned a bin with a plastic bin liner next to their chair. Throughout the meal we observed this person repeatedly lean over and regurgitate their food into the bin. We looked at this person's care plan which noted that they had swallowing difficulties but did not record that they were unable to keep food down and had not recorded how best to meet their needs in a dignified way. Although the person was undergoing medical tests this was not a dignified experience for them and was not a pleasant experience for those eating their lunch close by.

We found that two people shared a bedroom. There was a curtain between the two beds to provide some privacy however it was not possible to pull the curtain all the way across the room to provide adequate privacy when giving personal care.

People were not consistently treated with dignity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Many people living at York Lodge required support with communication. One staff member told us, "In York Lodge aside from their support plan we sit and ask their preferences and what they want." One person who did not engage in conversation or respond verbally to questions. Staff told us that the person did not communicate well. This was noted in their care plan but there were no details of strategies staff should use to effectively communicate with the person. We looked at another person's care plan and it said, "X has difficulty expressing herself or talking with sense. She can answer simple questions with yes or no but she can't hold a conversation." The care plan gave no guidelines as to how staff could effectively communicate and engage with the person.

We saw that residents meetings were held however the agenda for each meeting remained the same and included

Requires improvement

Is the service caring?

discussion regarding whether people were happy with cleanliness, meals, care standards and activities and did not appear to be accessible for many people living at York Lodge. We looked at the Service User Guide and the Terms and Conditions of Residency which were written in larger font but not easily accessible in content. We also saw there was a perpetual calendar in the lounge to help people to feel orientated in time. However, the board was not updated from the previous day's date until 11:15am when people had been sitting in the lounge for some time.

People's communication needs were not always respected and care had not always been designed to enable and support people to participate to the maximum extent possible. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

People told us they were given choice. For example one person told us they decided when they went to bed and we saw that staff offered at choice at mealtimes as well as when bringing drinks.

We saw that relatives were involved in care plan reviews. While we were inspecting the service, the family of one person had a meeting with their key worker to review their care plan. Relatives told us they were involved and one relative said, "Yes, anything that comes up, we are told about. We have a keyworker review every month, the keyworker makes notes and discusses it with the daughter," and another said, "We have a keyworker, it's one of the new girls. The prior key worker would go through the file, and update me and then I would sign them off." A keyworker is a named member of staff with special responsibilities for making sure someone received the care they need and that their views are listened to and acted on.

Inadequate

Is the service responsive?

Our findings

People said the staff responded to their needs and provided the care they needed. One person said, “Always feel I’m lucky, it’s been right for me” and another said, “They give you a shower and entertain you.” There were times when staff anticipated a person’s need without them having to ask for help and responded by providing appropriate help. For example we saw one member of staff notice that someone looked cold and brought them a cardigan saying “Look it matches your dress.” However we also saw that people did not have their needs consistently responded to.

Before people moved to the home staff carried out a basic assessment of their needs. We saw examples which included brief details of people’s care needs. Following this assessment staff developed a plan of care describing people’s needs and health in further detail. One staff member told us, “We get to know the person through observation and you get to know how they want their care needs met.”

On the first day of our inspection a new person was being admitted to the home. Some staff on duty were not aware the person was coming and when the person arrived by ambulance, the staff member who answered the door was not expecting them. The ambulance staff and care staff from the home held a conversation in the hall, in the presence of the new person and other people, that included intimate personal details of the person’s needs. We asked the registered manager what information staff had been given regarding this person’s needs. They confirmed that there was little information available. We looked at the persons care plan which was incomplete. It contained a one page care action plan that gave very little detail regarding the person’s needs. We looked at the pre-admission assessment which had been undertaken the week before. This was a two page document that consisted of tick boxes such as ‘wears glasses’ and ‘wears a hearing aid.’ Under communication it was simply ticked, “No problems.” The mobility assessment said the person required some physical assistance and used a frame. We looked at the hospital discharge notification which said the person had been admitted to hospital following a fall. Despite this the care plan gave no details regarding the assessment of risk or history of falls.

The section marked ‘Social interests, hobbies, religious and cultural needs’ was left empty. The “Care and family involvement” section was also left empty, as was the ‘Medication usage’ section. When we asked the registered manager about this, they acknowledged that the person had been admitted without sufficient assessment or information regarding their needs. They were aware the person had children but did not have their names or contact details. They had no previous address for the person, had not made contact with the person’s GP and had admitted the person with one suitcase from hospital. During the second day of our inspection we were told this person had not wanted to leave their bedroom and appeared to be confused regarding where they were.

The provider had not ensured that people received sufficient assessment before being admitted, in order to ensure their needs could be met.

Care plans had been reviewed and in some but not all plans, information had been updated when changes occurred. Two staff expressed the view that some people’s needs were such that they needed nursing care that was not provided in the home. The registered manager said they were aware that some people’s needs were becoming greater and had already supported one person to move to nursing care and named a further two individuals who may require nursing. They told us they sometimes struggled with making difficult decisions as to whether people could remain at York Lodge or should be moved to nursing care. We looked at care plans but did not see evidence that plans were updated in accordance with people’s changing needs. For example one person had recently visited hospital because they were having seizures, but their care plan had not changed following these episodes. This person had been allocated a reclining chair because of changes in their ability to maintain an upright posture. Staff had located this chair in a separate area of the lounge where the TV was on. We asked staff why the chair could not be located in the main lounge where the person’s relative had said they liked to sit. Staff told us that the chair was too big and there was not enough room in the lounge because part of the lounge was used for storage. There was no evidence in the person’s notes that staff had asked the person or their relative where they would prefer to be in order to find out and respond to this persons wishes and preferences.

Inadequate

Is the service responsive?

Staff told us that they discussed people's needs at handover and that there was a communications book for alerting staff to changes in people's needs. However, staff said that the timing of the handover meeting was such that they provided care to people for several hours before being told about their care needs and how they had been during the previous shift. Staff also said that the communications book was not used comprehensively and they were therefore not always aware of changes to people's needs.

Some of the people living at York Lodge exhibited behaviours that challenge. Staff we spoke with had not received training to help them respond to people who may present challenges to staff, other people or visitors. Staff told us about methods they would use which included walking away and returning to the person later when they were calmer. Staff also described using distraction techniques. However staff did not have a plan to respond to each person when they presented a challenge and to support that person in the most appropriate way. We observed staff trying to gain a person's co-operation regarding personal care. When the person became verbally and physically aggressive other people became visibly upset and shouted back, "Stop talking to her like that." and "I'm not letting her talk to you like that." The staff member did not appear to know what to do as they continued using the same approach. When this proved unsuccessful they said, "She's not in a good mood today, we'll leave her alone." They left the person, but returned later to try the same approach again. People did not receive responsive care that met their needs.

Care plans included a "My life before you knew me" record on which the person's life history, likes and dislikes could be detailed to help staff provide support and care in a way that responded to each person's needs. The notes recorded were very basic and sometime not filled in at all. We found that in a number of people's care plans "My life before you knew me" record simply stated, "Does not recall". There was no evidence that staff had tried to obtain information from other people close to the person. We found that people had limited information within their care plans about their interests, hobbies and how they liked to occupy themselves. One person said "What we do here is minimum, it's just filling in hours." On both inspection days we observed that people with the most complex needs spent long periods of time with no engagement in activity. Staff told us that where people's needs had increased they struggled to provide person centred activities and to engage those people who had sensory and mobility challenges. One staff member told us that those people with more complex needs lacked "Meaningful activities." They said, "The more able residents get the time from staff."

The statement of purpose described York Lodge as having "A beautifully laid out garden with a small greenhouse and some raised beds for residents who like gardening." We spoke with staff who told us, "Sometimes people go out (in the garden) with their relatives, but they don't go out much, no one ever comes out in a wheelchair." One relative told us, "When X first came in, we used to walk round the garden. Now they don't go in the garden as I can't get them up". Another relative told us, "In the summer months I would like X to get out in the garden a bit more."

The home's statement of purpose said, "There is a 22 seated minibus for twice weekly outings for residents who enjoy going out." Some people told us how much they enjoyed trips out, "We go out in the minibus, we all look forward to it, we just love to get out" One relative told us, "The bus trips are the best." One person told us, "I am so excited we are going out today, we don't know where, we never know." However, we asked one relative if their loved one went out and they said "No, (X) is not a walker, they only take the walkers on the mini-bus." We spoke with the registered manager about this and they explained that the minibus was not accessible to people who used wheelchairs. We asked staff whether they took people in wheelchairs out for walks and were told, "Outings are only for people who walk" and, "We used to take them out in their wheelchairs but we are too short staffed." We asked the registered manager to show us records of when those people who required a wheelchair had last been able to go outside, whether in the garden or further. They looked at the diary for 2015 which recorded when people went outside but were unable to find any records. We asked the registered manager to look at records for 2014. Where people's mobility had deteriorated the home had not responded to their changing needs. Some people had not been outside in eight months and others in nine and twelve months. One person's social life plan stated, "X lacks the ability to join the activities. X is always most of the time sitting comfortably in a recliner. Due to their poor mobility they can't join the outings either." The registered manager confirmed that the last time this person had been supported to go outside was in August 2014. The second day of the inspection the home had an entertainer who sang and played the accordion for over an hour. During this

Inadequate

Is the service responsive?

time the person this had been written about was smiling and clearly engaged. Where people were living with dementia and mobility difficulties the provider had not consistently ensured that their social and emotional needs were met.

One staff member told us, "If you spend time with them you will find a way to bring out the smiles and laughter but people don't get that time." Another person's social life care plan stated, "Due to poor mobility (x) can't join the outings anymore." Whilst the person required use of a wheelchair their care plan did not consider or give guidance as to when and how staff could support them to access fresh air and different surroundings.

The examples above show that people did not always receive personalised responsive care that met their needs. People with mobility difficulties were at risk of becoming socially isolated with little activity to stimulate or interest them. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People told us they were supported to maintain links with their family and friends. They said, "When visitors come we can go into another room and they bring a pot of tea" and, "My son comes most nights." Relatives told us they felt welcome at any time, "I feel totally welcome day or night" and "Friends come and visit as much as they want to."

The home had guidance on how to complain which included timescales for responding to complaints, a local advocacy service and details of the local government ombudsman should people feel dissatisfied with the way their complaint had been handled. People told us they could make a complaint at any time and would feel confident speaking to the staff or registered manager. One relative told us, "If I thought something was wrong, I'd bring it up…." However we observed that the complaints procedure was not displayed in a position that made it easily accessible.

We recommend that the registered provider reviews how they display the complaints procedure and other key documents in order to ensure people and their relatives have appropriate access.

Inadequate

Is the service well-led?

Our findings

Relatives told us that they felt the home was well run, that the management was fair and approachable. One said, "The girls are fantastic, the manager is fantastic, I wouldn't swap for all the tea in China." Another told us, "The manager is on top of everything that goes on, she is brilliant."

Staff told us, "I find the manager approachable, if there is anything we need we get it." Another said, "I understand that she has to be firm but she is supportive." However, we found there were shortfalls that the management team and their systems had not identified.

We looked at the environmental audits that had been undertaken and they had either not identified shortfalls or where they had these had not been addressed. The environment audit stated that, "The environment will be maintained appropriately to reduce the risk of cross-infection." The audit undertaken on the 28 May 2015 noted that "Structures were in place to ensure compliance and auditing of cleanliness." However we found this was not the case. Cleaning schedules were incomplete and where this had been identified in other audits, not rectified. We went around the home with the service manager who was responsible for maintenance and housekeeping. We showed them the ground floor toilet. It had no hand towel dispenser or paper towels for people to dry their hands and pipework was dirty. We showed them staining on the carpeted floor of the downstairs bathroom, a shower door made of marine plywood, holes in plasterwork and damaged paintwork. We looked at the top floor bathroom that had a bath out of use with a broken chair lift in it. The bath had a carpeted side panel and the toilet was positioned next to a wall of missing tiles. Whilst the management had been aware of this bathroom's condition for a number of months, the works had not been prioritised. On the maintenance action plan the works were noted as a project for improvement rather than a health and safety or infection control matter.

We also showed them a broken toilet door lock, places where handrails were missing on the staircase, and where access was restricted for people who used mobility aids, all of which they were unaware of. We asked the registered manager how they were unaware of the issues such as the downstairs toilet and was told this was because they used the toilet that was dedicated for staff. The management had not undertaken sufficient checks and monitoring.

The registered manager told us the provider lived abroad and had not been in the home for eighteen months. Staff told us they thought the provider could do more, "They could do an awful lot more, from what I see they could make the environment better- everything better." Another told us "The owner, I have only met him once." The provider operated a system of monthly visits where a visiting manager undertook an "inspection of premises" and an "inspection of records." These also had failed to identify or address issues highlighted during our inspection. The visit records were brief, with very little detail and we found that many comments made by the visiting manager were repeated month after month. For example, in the inspection of premises sections for the reception/entrance, lounges, offices, cleanliness, as well as the "service user appearance section" there was little detail and all were described as "Clean and tidy". In the inspection of records section, we saw that there had been no inspection of care plans since March 2015. Risk assessments, fire records accident and incident records, service user finances and kitchen records had not been audited as part of the monthly visits with no record of inspection in March, April, May or June 2015. Systems to monitor and assess the quality and safety of the service were not effective in that they had not always identified issues or ensured improvement.

The records were not always completed or accurate. For example we looked at accident and incidents reports and they had not always recorded what action had been taken to remove the hazard and prevent recurrence. One record from February 2015 reported that someone had scratched their hand on a screw sticking out from a toilet rail. The record did not include what action had been taken as a result of the incident. Accident and incidents for June 2015 showed that one person had fallen twice in one week but there was no record of what action had been taken. The registered manager showed us their monthly accident and incident audit dated June 2015. This noted that the accident and incident forms were not completed in full however the audit itself failed to identify lessons learnt and

Inadequate

Is the service well-led?

record action taken. The audit noted that "none had been taken to hospital" when the person's individual records showed otherwise. This showed that records were not effectively completed.

Peoples care records including those designed to show when people had been helped to have a bath or shower were not consistently completed. When we asked the registered manager to show us when people had last bathed they acknowledged that records were incomplete and had to look though daily logs to find a record. Although care was being given, records did not consistently record this. This meant staff were not alerted when care may have been refused or not delivered.

There were other records that were not being completed properly and as they were intended to be used and these included the fire list and the dietary requirement lists both giving inaccurate information. One person's care plan said, "X is having her meals at the dining table, together with other residents." However we observed this had not been put into practice. When we asked the registered manager, she confirmed this was out of date and a recording inaccuracy.

People who used services were not protected against the risk of unsafe or inappropriate care because the registered provider did not have effective monitoring systems in place and records were not always accurate or up to date. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home's code of practice, values, ethos, philosophy, aims and mission statement were displayed on the notice board in the manager's office. Staff we spoke to had a good understanding of the aims of the service. Staff told us that staff meetings were held regularly and that they felt able to voice concerns. We saw minutes from meetings involving care staff and housekeeping staff and these indicated that staff felt able to put forward suggestions for improvements to the home. Staff told us that they felt confident that managers would take action when they put forward suggestions. Staff said the registered manager listened to them and acted on their views. "Whatever we need, we tell the manager and they pass that on to the owner." Staff had requested a new standing hoist which the manager agreed was needed and bought.

We spoke with the registered manager about how they sought the views of people, relatives and staff. There were regular newsletters and meetings held for people and their relatives. There were relatives' meetings every month which were attended by three to four relatives and minuted. Relatives that attended told us they were always asked "Is there anything we could do to improve? One relative said their relative had been at York Lodge for nearly four years and they had never needed to raise a concern. Another relative said "Yes once a month there's a relatives meeting, we go through Health & Safety, cleanliness, etcetera, it's open for discussion, that's when I brought it up about X's chair." We saw from the minutes of meetings that the registered manager had encouraged feedback from staff and relatives.

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	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People were not protected from undue restriction as assessments of people's capacity to make decisions had not consistently been undertaken.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risk of unsafe or inappropriate care or treatment as risk assessments were not sufficient. People were at risk of the spread of infection as the home's maintenance and décor did not enable effective cleaning. The registered provider had not ensured that people received their medicines according to their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People did not receive the support required to ensure their meals met their personalised needs.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had not ensured the home was maintained and equipped to an appropriate standard that met people's diverse needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider failed to ensure that there were sufficient numbers of staff deployed to safeguard the health, safety and welfare of people. Staff did not have the appropriate training and skills to effectively support people.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People did not always receive person centred care and support in a way that met their changing needs. People were at risk of becoming socially isolated with few person centred planned activities to meet their needs.

The enforcement action we took:
We served the provider with a warning notice. We asked the provider to achieve compliance with the regulation by 10 October 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not protected against the risk of unsafe or inappropriate care because the registered provider did not have effective systems in place for monitoring the quality and safety of the service and identifying when there were issues or acting to make improvements.

The enforcement action we took:
We served the provider with a warning notice. We asked the provider to achieve compliance with the regulation by 10 October 2015.