Care Quality Commission

Prime Life Limited

Westerlands Nursing Home

Inspection report

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Ratings

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

Overall summary

The inspection of Westerlands Nursing Home (known as Westerlands Care Village) was on 7 April 2015 and was unannounced. At the previous inspection on 26 June 2014 the regulations we assessed were all being complied with.

Westerlands Care Village provides a service to a maximum of 62 older people who may have nursing needs or who may have a health diagnosis that means they live with dementia.

We found that some records weren't always sufficiently well maintained to ensure accuracy of information about people and their care or healthcare needs. While these did not impact majorly on people there may have been times when people did not receive the care, treatment or support they required. We observed this during our visit. There were other records on recruitment, medication, monitoring charts, accidents and staff training that were inadequately maintained and while impact on people was minor there were too many areas of the service affected which meant that inadequate record keeping was systematic in the service.

This was a breach of regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014. Regulation 17 refers to good governance. You can see what action we have asked the provider to take at the end of the full version of this inspection report.

Summary of findings

We found that most of the staff were trained in safeguarding adults from abuse, but not many were trained in management of medicines and moving and handling. There were satisfactory numbers of the staffing complement that had been trained in dementia awareness. The nursing staff employed did not have evidence of the training courses they had completed and one nurse did not have evidence of their Nursing and Midwifery Council personal identification number. Some improvement was required in this area.

We found that there were suitable arrangements in place to ensure safeguarding incidents were tested against the East Riding of Yorkshire Council Safeguarding Adults Team thresholds for referral, were referred when they crossed these thresholds and were dealt with internally when they did not. Staff understood what constituted abuse and were able to tell us the signs and symptoms they would look for. They also understood their responsibilities regarding reporting and handling information, either of an allegation of abuse or actual abuse that has taken place.

The premises were safe and adequately maintained, but decoration and furnishings did not assist in the care of people living with dementia. This was discussed with the registered manager and regional director – northern. They undertook to research some of the excellent work being done around the country on dementia care. This was so that the service could be adapted to incorporate signage, make use of appropriate colour and décor and move towards providing meaningful activity / occupation for all of the people living with dementia at Westerlands Care Village.

From looking at the staffing rosters, observing staff providing support and speaking with people and their visitors about staffing levels we found that numbers of care staff were sufficient to meet people's needs if they did not have to carry out ancillary duties. However, the deployment of staff could have been improved to ensure people's needs were met more effectively and in a timelier manner regarding their medication, assistance with getting ready for the day and engaging in more occupation.

Recruitment of staff followed appropriate policies and procedures but implementation of the systems required tightening up to ensure they were more effective at evidencing staff were suitable and appropriately trained to work with vulnerable people.

We found from speaking with staff, observing staff giving out medication and assessing the systems for management of medication that medicines were safely handled, but recording in this area needed to be more carefully undertaken to ensure accurate records were held.

The service appropriately managed the use of the Mental Capacity Act 2005 and its associated Deprivation of Liberty Safeguards legislation which ensures people's rights are upheld and they are legally represented at times when they are unable to exercise capacity decisions.

The service provided people with adequate nutrition and hydration and while the meals weren't always to everyone's liking they offered some choice and were plentiful. People had mixed views about the provision of nutrition and we judged that breakfast could have been offered at a more appropriate time, but we found there were no concerns about the quantity and quality of food people received.

We found that staff were caring with regard to the physical care needs people presented but were not always attentive to people's emotional and mental health care needs. This was not as a result of lack of compassion, more a result of the deployment of staff which meant they had insufficient time to enquire how people were and spend time with them providing quality conversations.

Confidentiality and privacy were adhered to so that people knew their intimate details would not be passed among other people that used the service and they received support with personal care in private. Dignity was adequately upheld but there were isolated situations that could have been thought about more carefully. Where possible people were encouraged to be independent in thought and deed.

People had care plans in use to record their assessed needs, inform staff how best to meet those needs and to

Summary of findings

show changes to care provision and support following changes in needs. Care plans followed a uniform format, were reflective of people's needs and were kept up-to-date.

Complaints were appropriately listened to, recorded, investigated and managed. Complainants received appropriate written responses and efforts were made to improve situations for people. Staff were not always fully informed of the best way forward following a complaint, which meant their practice was slow to change and so sometimes people and their visitors felt complaining was ineffective.

The service cooperated well with other organisations, care providers and health care professionals, so that people received optimum care wherever possible when more than one care provider was involved.

The service has had a newly registered manager in post since 20 March 2015. There have been some changes in the staff group over the last 12 months and new staff were being recruited when we made our inspection visit. Information we obtained from the registered manager, staff, people that used the service and their visitors showed there was a tentative confidence in the new management team, though we judged that the registered manager needed to have a more visible presence.

Prime Life Limited still operated a quality assurance system in Westerlands Care Village, which required further development with regard to collating and analysing information and presenting its findings to people. There was evidence that audits had been carried out in June 2014, but there were gaps in their action planning. We were shown some new satisfaction surveys that were to be issued to people, visitors and stakeholders. These needed to be used to obtain people and stakeholder's views of the service they received.

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?

Requires Improvement

The service was safe, but required improvement.

People that used the service were protected from the risks of harm or abuse because the provider had ensured there were systems in place to detect potential and actual abuse. There were systems in place to ensure safeguarding referrals were made to the appropriate department. The majority of the staff were appropriately trained in safeguarding adults from abuse. Some staff required documentary evidence of their safeguarding training.

People were safe because whistle blowing was appropriately addressed and investigated and risks in the service were reduced. While staffing was in sufficient numbers to meet people's needs there were minor problems with staff deployment, so that some people's needs were not met in a timely manner. While staff recruitment followed safe policies and practices these needed to be tightened up to ensure systems were used as effectively as possible when recording evidence of staff suitability. Medication management and infection control practices were suitably handled.

This meant that people who used the service were protected from the risks of harm.

Is the service effective?

Requires Improvement

The service was not effective.

Staff training could have been better in management of medicines and moving and handling and the nursing staff had gaps in their training in these areas as well. People were protected from having their rights denied because the service used the mental capacity act and deprivation of liberty safeguards legislation in an effective way. People were provided with adequate nutrition to meet their needs. While the design of the premises were suitable the adaptation of the environment was not helpful in caring for some people living with dementia.

This meant that people were not always cared for and supported by staff that were trained and competent to do their jobs, but people's rights were upheld and they ate sufficient amounts of adequate food. Some people living with dementia did not benefit from an environment that was suitable to their needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Summary of findings

People were cared for and supported by staff that understood their needs, were kind and attentive. However, staff could have considered people's dignity more carefully to ensure their intimate care and health care needs were always less obvious to others. People experienced a helpful approach from staff and were adequately cared for with regard to their physical needs.

Is the service responsive?

Good

The service was responsive.

People were cared for according to their written care plans, which were appropriately reviewed and changed whenever necessary. People had some opportunity to undertake activities but occupation for those living with dementia could have been better. There was an appropriate complaint system in place that had been used by people and their visitors. The service cooperated well with other organisations and care providers.

This meant people received the care they needed, engaged in some pastimes if they wished and had their complaints addressed in order to improve their quality of life.

Is the service well-led?

Requires Improvement

The service was not well led.

While the service had a registered manager in post there had been management and staff changes and therefore an unsettled period when people had poor consistency in care support. There was a quality assurance and auditing system in place but people were not always asked their views about the service. Some records weren't always sufficiently well maintained to ensure accuracy of information.

This meant that people's care wasn't always consistent and they didn't fully benefit from having any shortfalls in the service identified and improved upon.

Westerlands Nursing Home

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 took place on 7 April 2015 and was unannounced. The inspection team comprised of a Lead Inspector, a second Inspector, an Expert-by-Experience (ExE) and a Specialist Professional Advisor (SPA). An ExE is someone who is a person who has personal experience of using or caring for someone who uses this type of care service. The area of expertise our ExE had was in dementia care and care of older people. An SPA is someone with specialist knowledge and experience working in a specialist field of care. Our SPA was an Inspection Manager undertaking a master's degree in dementia care.

We looked at information we already had on our system in the form of statutory notifications, whistle blowing incidents, 'tell us your experience' and the Provider Information Return (PIR) we had received from the provider when we requested it. A PIR 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.

Our inspection also included a visit to Westerlands Care Village, during which we spoke with eight people that used the service, five relatives and seven staff. We looked around the premises. We observed some of the care interactions between people and staff using a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who cannot talk with us. We saw lunch being taken in Elloughton House one of the two buildings that comprised Westerlands Care Village.

We looked at four care files for people that used the service. Care files contain information about people as well as their care plan document. The care plan document specifically explains to staff how they can best support people with their care needs. We also looked at six staff files, training records, rosters, quality assurance audits and satisfaction surveys.

We received information from the East Riding of Yorkshire Council Quality Development and Monitoring Team after they had completed some visits following concerns raised. Their findings are incorporated in this report

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Westerlands. They said "Yes I am safe here, staff are about, the room is good", "I'm quite safe, up to now I have had no problems" and "I've a lock on my door." They told us that people were kind to them.

Relatives we spoke with said, "I would say V is safe, safe from falls as V doesn't walk. Some residents can wander into V's room, they're just lost, but staff take them out" and "I think W is safe and secure, but I am concerned if staff are fully trained to use the hoist. I feel I have to come every day to make sure W is okay."

People said they took few risks these days but tried to do what they could. They said, "I cannot do a lot for myself, but I use my wheelchair with help from staff" and "I have this trolley frame to keep me safe from falls." They felt they were safe when staff were caring for them and that there were sufficient staff available to look after them. People said, "I think staff are good, they're friendly" and "The ones that I see, most of them are good, not naming names." They also said, when asked about the call system being answered, "I'm not waiting long when I call for help", "Even when the place is short staffed I still get the care I need", "I don't have one (call bell). I shout for staff, but the wait isn't very long" and "I very rarely use it (call bell), on the whole it (the response) is pretty good."

Staff we spoke with told us they had completed safeguarding training with Prime Life and they demonstrated a good understanding of safeguarding awareness when we asked them to explain their responsibilities. We saw from the staff training record and individual training certificates that 70% of care staff had completed safeguarding training in the last three years. Other staff training has been addressed in the section below on 'effective'.

We saw from the information we held on our system that there had been 21 safeguarding referrals to the East Riding of Yorkshire Council (ERYC) Safeguarding Adults Team in the last year, all of which had been notified to us. While the service experienced a high number of safeguarding incidents (18 were between people that used the service, one was an allegation against a staff member and two involved family members) we judged that the service acted appropriately and quickly in respect of each one. Safeguarding records held showed that all incidents were addressed, investigated and learned from.

We found that the service had information about the new ERYC safeguarding thresholds for referral and there was evidence the new forms had been used. We expected that future months would see fewer referrals being made because of the new threshold system being implemented.

When we looked at care files we saw that people had individual risk assessments in place which had been reviewed. They covered falls, moving and handling, skin integrity, use of a lifting hoist, nutrition, smoking and interactions with others. We saw that the service had generic risk assessments in place for staff to follow, with regard to ensuring everyone's safety in the service and relating to fire hazards, use of cleaning equipment and materials and working in the kitchen or at height for example, but these had not been reviewed since March 2013. This meant that the information within them may not be up to date.

We saw that the premises were in a good state of repair in both buildings at Westerlands Care Village. Maintenance certificates were available to back up the programme of maintenance carried out. We saw that the last gas safety certificate for Brough Lodge was dated 2 January 2015. We saw that fire extinguishers and the fire alarms had been serviced in January 2015, the fire sprinkler system had been checked in September 2014, fire doors, fire windows and emergency lighting in March 2015, lifting hoists in November 2014, portable appliance testing in April 2014 and a five year electrical safety certificate was obtained in February 2012. This meant that regular checks were being completed to ensure that equipment was safe. Décor and furnishings were in a good state of repair and were safe for people that used the service.

The service had emergency plans in place for fire, flood and electrical issues. These had been reviewed in April 2015 and were available to staff and maintenance staff.

We saw that the service had information for staff regarding Prime Life's whistle blowing policy, which the registered manager told us all staff had been instructed in during

Is the service safe?

induction, supervision or via Prime Life's '60 second learning' guides. When we spoke with staff they told us they were aware of the policy and had received instruction in whistle blowing.

We saw that when people had an accident they were provided with the medical treatment they required. Accident records were individually maintained for each person.

All of this meant that people were protected from the risks of harm and abuse that could arise from the risk of dangers within the premises.

At the beginning of the inspection visit we asked the administrator which staff were on duty and checked the staff names given to us with the staff we met in the service and with the information provided on the staffing rosters. We were told by staff that there was one clinical lead on duty and one senior carer on duty. We saw copies of rosters for four weeks between 16 March and 12 April 2015, which included the day of our inspection visit.

We observed that there were 19 care staff on duty (this included the clinical lead nurse and a senior carer). We were told there were 19 people in Elloughton House and 31 people in Brough Lodge. Eight staff provided one-to-one or extra care to seven people at some time of the day (one of these staff went off duty at 2.00 pm and was replaced by another staff member to compete the one-to-one support). The clinical lead and one senior carer were 'floating'. This meant those people not receiving one-to-one support, 47 of them, were being cared for by ten staff in the morning and nine in the afternoon. This looked like enough staff to meet people's needs but care staff were deployed to provide some ancillary chores as well as care: collecting and serving meals, clearing away and pot washing. Therefore all of their time was not spent with people meeting their needs.

We judged that inefficient staff deployment had an impact on the service people received. During our observations we saw that some people in Elloughton House did not receive their medication in a timely manner. We saw that some people in Elloughton House were given their breakfast by care staff at 09:45 am. At 10:00 am one person told us they had been waiting to be assisted downstairs since 09:00 am when they got up. They said, "Staff told me I would be taken downstairs in ten minutes, but an hour later here I am still waiting." We assisted this person to access the lift and to go downstairs. We later saw this person eating their breakfast at 10:50 am. We observed that no one in Elloughton House used the dining room to take breakfast and only one person used it to take lunch. People remained in their lounge chairs for both meals. This did not encourage people to move and take exercise.

Discussion with two staff in Brough Lodge revealed they worked from 08:00 am to 08:00 pm, began to assist people to get up from 08:30 and usually found mornings to be "Rushed". They said that they helped people to use the bathroom, to wash, dress and take breakfast and then they washed breakfast pots, assisted anyone rising late to get up and have some breakfast. They said, "Before we know it, it is lunchtime." They explained that there was no ancillary staff to tend to meals and clear away after meals. One staff told us they had to go and collect the lunch from the kitchen and left the lounge at 11:55 am. We saw this staff member and two others waiting outside the kitchen to collect lunch as we left Brough Lodge at mid-day. This meant the units on Brough Lodge and Elloughton House were one care staff member short during this waiting period. If ancillary staff carried out these catering tasks: collecting and dishing up meals and washing pots afterwards, there would be more time for care staff to spend assisting people with their needs.

While the provider assured us there were sufficient staff on duty to meet the needs of people that used the service we were not confident that the deployment of staff was efficient, as we observed that some people experienced inadequate support. The accounts of late medication and taking late breakfasts mentioned above and the deployment of care staff to serve meals and clear away afterwards were the reasons for this. We saw that staff assisted people with personal care in bathrooms and toilets and then served breakfast or collected meals form the kitchen and dished them up to people. These practices may have risks unless staff ensure they follow policies on cleaning, hand hygiene and food hygiene and unless there are clearly defined roles and responsibilities for cleaning and handling food. The service assured us this was the case. Information we received from ERYC was that they had visited to look at staffing levels following concerns that had been raised. ERYC have been carrying out monitoring visits.

We recommend the provider considers staff deployment to ensure roles and responsibilities are clearly defined and followed.

Requires Improvement

Is the service safe?

When we interviewed staff we asked them about the process they had completed to secure their jobs with Prime Life. They told us they had completed application forms, provided references, attended interviews and had to be cleared by the Disclosure and Barring Service (DBS).

We looked in staff recruitment files and saw there was evidence of this in the form of application forms, references and DBS checks or the predecessor Criminal Records Bureau (CRB) checks. Files showed that staff had been given job descriptions and contracts of employment.

One staff member's file belonging to a staff working on the day we visited, but newly recruited with a start date of 30 March 2015 (just eight days before our visit), only contained a DBS First check. (This is a pre-check that providers can obtain in advance of the full DBS check.) The roster for the inspection day indicated that this staff member was working as one of the complement of staff on duty and there was no information to show they were an extra staff member undergoing induction or being mentored. When we asked the administrator about the DBS check they told us the staff member had received it but had not brought it in for verification yet. Therefore we judged they could have been working as a care staff member without a full DBS check in place. There was no information to show how this staff member was supervised while working without validation of their DBS check. This was a problem related to record keeping. Other files we saw had appropriate DBS checks in place.

We assessed the medication management systems used by the service and saw that medication was appropriately requested, received, stored, administered and returned when not used. The service used a monitored dosage system. This is a monthly measured amount of medication that is provided by the pharmacist in individual packages and divided into the required number of daily doses, as prescribed by the GP. It allows for simple administration of medication at each dosage time without the need for staff to count tablets or decide which ones need to be taken when. We saw that medication administration record (MAR) sheets were in use and that they accurately recorded when people had been given their medication.

When we asked people about their medication they said, "The staff bring them to me", "I won't answer that – they are always brought at the right time" and "They (staff) bring me all my medications." People were unsure if they could self-administer their medication.

Visitors said, "Sometimes medication is in liquid form, sometimes in tablet form which my relative struggles to take. My relative is supposed to have supplements three times a day, but one day last week the morning one was not given. Sometimes supplements are given before I arrive at 9.30am, other days it is nearer lunchtime", "I don't know much about it" and "Medication was given at 3.45 pm and my relative should have had it at lunchtime."

We judged that medication could have been administered in a timelier manner in Elloughton House. We saw that some people in Elloughton House did not receive their morning medication until 10:30 am and one person did not receive it until 10:50 am. The staff administering medication told us they had begun the task at 08:30 am but had been interrupted several times to assist with other tasks. They also said that no one was ever hurried regarding taking their medication. However, they acknowledged that the 'round' didn't usually take as long as it had done. We were concerned that some people would need their second dose of medication later than prescribed on the MAR sheets and that anyone with memory impairment might become confused about whether or not they had taken their tablets that day. However, we were later told by a relative that their family member was given their lunchtime medication at 3:45 pm, which showed that medication was adjusted following the lateness of the morning 'medication round'.

We discussed with the clinical lead on duty how medicines were managed and administered in Brough Lodge. They told us that a stock balance check on all medicines was completed each month. Medicine checks we carried out showed that stocks balanced with the records and they had been administered in line with the written instructions provided. There was one eye drop bottle that had not been dated on opening it, so it could have been administered after the 28 day period to safely use it had expired.

We saw that the service managed the use of controlled drugs well. They were appropriately stored, administered and recorded. We were told by the clinical lead that there were eleven people on anti-psychotic medicines, which were appropriately handled.

The service had a copy of 'Managing Medicines in Care Homes' dated March 2014.

Requires Improvement

Is the service safe?

While management of medicines were safe we judged that they could have been administered in a timelier manner in line with MAR sheet instructions.

We recommend the provider ensures people receive their medication according to the instructions and times listed on the MAR sheets.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us they thought the staff knew what they were doing in their roles. They said, “The staff are good” and “They seem to know what they are doing.” Visitors we spoke with told us, “Some staff are excellent, one not very good. I sometimes ask for things and they never come”, “I think they are getting there, there's been a lot of change” and “On the whole they are obliging.” Another response was, “I don’t think they are trained enough - don’t think they are trained properly initially.”

We saw that the number of care staff on the April 2015 training record, excluding nurses, was 37 with 12 bank staff; a total of 49. Of these 49 staff the record showed that 12 (25%) had completed management of medicines training, 34 (70%) safeguarding adults from abuse training, 29 (60%) moving and handling training, 29 (60%) infection control training, 45 (92%) fire safety training , 35 (72%) dementia training and 40 (82%) mental capacity training. (All training on the record dated as completed between 2012 and present day was taken into account. Some of this was corroborated in our discussions with staff.)

The registered manager told us they knew that staff needed continuous training and offered training appropriate to meet the needs of people. However, staff did not always keep training up-to-date. The record showed that from a total of 49 care staff five had completed safeguarding training more than three years ago, another six had completed it two years ago and there were 15 staff that had no record of when their last safeguarding training had taken place. This related to half the staffing workforce. We saw that eight ancillary staff had completed safeguarding training between 2011 and the date of our inspection visit.

We saw that a newly recruited staff member had no details of any induction or training in their file. When we asked the administrator about staff induction training they told us that new staff completed a two day orientation and a corporate induction of thirteen weeks where they read policies, learned about fire safety and completed basic training. When we asked the administrator what training the new staff member had completed regarding moving and handling and the use of hoists we were told that they had not completed any yet, as this would be undertaken in the induction period.

While we had some concern because their file stated they had no prior experience in caring and the roster showed they were working as part of the full complement of staff, we were told by the administrator that the staff member would not be expected to assist people with transfers before they were fully trained. They would call upon another staff member to carry out the task for them.

We evidenced later that this staff member was booked on a moving and handling course with other staff, which was planned to take place three days after our visit. We saw there was no information in the file to show how this staff member was supervised while at work, without appropriate training in moving and handling or hoist use.

The training records we saw that belonged to three of the five trained nursing staff employed at Westerlands were lacking in information. We saw in two nurses files that neither had any training records. We asked for information on all of the nurses training to be sent to us after the inspection and we received two documents. One belonged to a nurse whose file we had seen. It only contained details of up-to-date training in diabetes awareness. The other document was for a nurse whose file we had not seen and it contained details of up-to-date training in oral hygiene, fire safety, infection control and whistle blowing.

The clinical lead on duty (one of the five trained nurses) told us they had not completed any updated training in management of medicines in the last 15 months. Though they were named on the service training record there was no date for them having completed medication training. We saw that medication was not listed as being completed on their personal training record. We were told by the registered manager that the clinical lead and one other trained nurse had transferred from another registered service with Prime Life Ltd and so their training details held by Westerlands were not yet fully up-to-date.

When we spoke with a visitor to the service they told us they were concerned about the staff in Elloughton House giving out medication. They said, “J (staff member) is giving out meds today, though J is not a senior. I am unsure as to whether J should be giving medicines out.” The staff member J told us in interview they had completed management of medicines training. While there was no recorded date on the staff training record to show that this

Is the service effective?

staff member had completed management of medicines training we were later informed by the regional director – northern that other documentary evidence of this staff member's training was available.

We judged that trained nursing staff had insufficient information to evidence they were all trained in safeguarding adults from abuse, medication administration, infection control, moving and handling, fire safety and dementia awareness. We judged that some care staff had gaps in their training as well. All of these findings were an issue with training records and information held by the service being inaccurate and has been reported in the section on 'well-led'.

We understood that monthly checks were being carried out on staff training up-dates. We found that these monthly checks were ineffective as they did not ensure training records were accurate. We were told that there were plans for 9 and 12 staff to complete moving and handling (with hoist) training on 10 and 17 April 2015 respectively and we saw the candidate lists for these.

We saw from staff files that they received supervision and annual appraisals. These were appropriately recorded. Staff confirmed in interviews with us that they received supervision. However, we saw in files of two trained nurses recruited in November 2014 that they had not yet received any supervision. This meant there was inconsistency with implementing the supervision systems in place and so the service would benefit from improvements being made.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. When we spoke with staff they had an understanding of the MCA and DoLS legislation and they told us they had completed training in these areas. The records showed that 82% of them had completed this training.

Where necessary the service held 'best interest' meetings. This is a multi-agency approach used to assist people with no capacity to make important decisions about their lives to make a specific decision that will affect their health and wellbeing. We saw that people's care files contained appropriate information and records relating to when a 'best interest' meeting had been used. This meant people's rights were upheld and the appropriate legislation was used to protect them from receiving the care and treatment that was not in their best interest.

People and their relatives told us they had mixed views about the provision of food and drink. They said, "The food is usually very good, though I don't get a choice in what they bring me", "We get a choice of meals, though I sometimes get bored with sandwiches", "We usually just have what comes. Don't we X? But we don't grumble about it as there is plenty" and "I eat most things and the food is all right." Other comments included "I can't tell what it is, (soft diet) but food for others looks good", "Seems good, smells nice, usually hot", "Food is just okay", "Soft foods are given to Y", "Z is on a diabetic diet, they (staff) know what Z can have" and "The food's okay but could be better, I have to go and buy wheat-free soups and yoghurts." We were later informed that this was a matter of personal choice as these items were available on prescription for the person concerned.

We were told by staff that people received a choice of meals, but in Elloughton House we heard the staff offering only porridge or Cornflakes for breakfast, which was followed by toast and preserve if people wanted it. At lunch time in Elloughton House we saw that everyone was given the same dish of lasagne with potatoes. We acknowledge that this may have been the meal of everyone's choice that day. People ate their meals and expressed they had enjoyed them and the food looked appetising. There were no menus on display in Elloughton House for people to know if an alternative was on offer.

We recommend that the provider ensures that there are menus on display in Elloughton House so that people know what choice of foods are available at meal times.

We were informed by a visitor we spoke with that their relative had no intake chart in their bedroom and they would have liked to have seen them because the person had a diagnosis of diabetes. We were later told that this person did not require intake charts because there were no issues with their diet or food and fluid intake.

Requires Improvement

Is the service effective?

We saw that food for the whole site was centrally prepared in Brough Lodge and delivered to all units in hot food locks. Some people received support with eating their meals and this was carried out sensitively and with regard to people's needs.

We saw that people received treatment from the nurse on duty if they were assessed as requiring nursing care and from visiting district nurses if they were assessed as not requiring nursing care. These people may have had a temporary nursing need, for example, a wound that needed dressing or insulin injections given to them. Care plans contained details about people's assessed health needs, conditions and diagnoses. Health action plans told staff how best to meet these needs. We saw that people had access to a GP if they required or requested one and there was a record of healthcare professional visits held in people's files.

Of the properties at Westerlands Care Village one was traditional and the other was modern. Both were comfortable and appropriately maintained. We were informed by the area manager – northern that the modern building had been designed and built using the research by Stirling University, leaders in dementia care on premises suitable for people living with dementia. Further research by the Kings Fund provides information about internal living environments, which the service is made aware of in this report, as living environments were not the best they could be. The living environment in the traditional property, we were informed, did not need to conform to any specialist dementia guidance as the people that lived there were not living with severe dementia. The modern property did not have suitable furnishings, and appropriate signage for people living with dementia was lacking. While there was some stimulation and occupation for some of the people living with dementia, there was none for others.

We recommend that the provider considers and adapts some of the current research so that people living with dementia can benefit from an environment that takes into consideration their care needs.

Requires Improvement

Is the service caring?

Our findings

People told us they liked the staff. They said, "Staff are nice, they're helpful", "They (staff) usually treat me okay", "She (pointing to a staff member) is a lovely girl, I like her", "The girls are really good, we have such a laugh with them", "I love that nurse there (pointing)" and "The staff are okay once you get hold of them."

We heard some interactions between people and staff that were jovial. One staff said to one person, "Oh there you are. Come on then mother." They both laughed and the person told us in a very jovial manner "They're bullies here you know." We heard other people speaking with staff in a similar vein and we also heard people speaking with staff more seriously and earnestly. One person living with dementia kept telling staff they had pain in their arm. Staff knew about this and while there was no more they could do regarding pain relief, they showed sympathy and care and tried to take the person's attention away from it by engaging them in a puzzle.

Visitors told us that their relatives were "Quite well cared for." When asked their opinion of the staff approach they said "Variable, ones that are good are excellent", "Staff seem to be caring, they are always approachable" and "Some staff are caring, they're mostly helpful."

We observed some positive interactions between people and staff throughout the day. People were given time to get ready for the day and time was taken with them to take their medication. They were not hurried in any way. However, the effects of this approach were that some people felt frustrated with their wait to be supported. One person said, "I've waited an hour to go down for breakfast" and two others said, "I haven't had my medication yet" and "We haven't had a cup of tea this morning." Other people did not mind at all and told us they just let things happen whenever. One visitor told us, "I had a complaint a while ago, as I had arrived at 11:00 am and X had had no breakfast and was still in bed."

People were asked about their meal choices and they told us these were respected when a choice was offered. Some people were offered the chance to go outside for fresh air, a walk around the garden or in the local community and to have a cigarette if they smoked. We saw staff speaking with some people about their family or what they used to do when they were younger and trying to engage them in pastimes: reading the newspaper, doing some drawing, flicking through a book of interest. Staff were polite to people and showed patience.

We saw that some people were friends with one another and passed the time of day chatting and laughing, others remained less involved. Some people did not demonstrate to us that they had developed relationships with others and we were unable to speak with them to ask about it. We spoke with one person who was visited by their spouse. They said they hoped they could go home, but the spouse told us they visited daily to maintain the relationship they had shared for many years. Other people maintained family relationships through regular visits from their family members. People and staff related well, though some staff concentrated more on the tasks to be managed than on people's wishes and choices.

We observed some staff asking people to make choices when they could and involving people in their care and support. Staff gave adequate information and explanations to people to engage them in a task and gain their consent for care to be given. Sometimes staff made some of the decisions in people's best interest because people were unable to. People that did have capacity said, "I have no control over my decisions", "Staff do everything for me" and "Staff choose my food and on the whole they choose when I get up and go to bed really, on account of my physical needs." We judged that while some people were unable to exercise choice, others could be given improved opportunities to make their own decisions about their daily routines.

People told us they did not know if they had received any information about the service, as they could not remember. Relatives we spoke with thought the information they received about their family member living at Westerlands was sometimes insufficient. They said, "I receive no information unless I ask, but X has two daughters who are kept informed" and "I receive no information about Y who has no intake chart in their room, so I don't know what they have eaten or drank." This person would have liked a chart to view as it would have been helpful to them. Another relative said, "I am here every day, I ask them (the staff) about Z every day."

While we saw staff attending to people's physical needs we did not hear any staff asking people about their general wellbeing. One person was clearly unhappy about having

Is the service caring?

to wait to be assisted downstairs and this prompted them to say, "I can't stop here, it's terrible." However, when we saw them later they were comfortable and were eating a late breakfast. They said, "I'm fine now I have my breakfast." Another person stayed in bed as they said they were ill, but when we asked them how they felt emotionally they told us they couldn't be bothered with much and just wanted to get well so they could go home.

We recommend the provider ensures staff enquire about people's emotional well-being.

On the subject of advocates people could not remember if they had been given any information about this and one person said, "My niece is my advocate." We did not see any written information about advocacy services.

We found that everyone that required assistance with personal care was encouraged to receive it in private. When people spoke with staff about issues staff maintained confidentiality and only discussed the issues generally, thus maintaining people's privacy where possible. People and visitors told us they felt privacy and dignity were respected. They said, "I think the staff respect my privacy and care for me in a way I want to be cared for", "Staff always close the door and I leave the room when they give A personal care", "Staff are pretty good at this, curtains and doors are closed" and "The staff close the curtains, privacy and dignity always seem okay."

We saw that some people needed guidance with maintaining their dignity, for example assisting people to change after having a continence problem, showing them to the bathroom and allowing them to be independent and assisting people to eat when their motor skills were impaired.

However, we also saw some examples where people's dignity was not respected; for example, one person still had a night catheter bag on when they came down for breakfast instead of a more discreet day bag. In Brough Lodge 'Garden Suite' at 11:35 we observed one care staff member providing one-to-one support to a person in the lounge and there were seven other people there as well. One of these seven people repeatedly asked if they could be given some help to go to the toilet. The staff providing one-to-one care responded each time telling the person the other staff would be back in a minute to assist them. After telling the person several times that the staff would be back in a minute the staff member then said, "You've got a pad on." The person answered, "Oh that's alright."

At 11:45 two staff came into the lounge with a ninth person in a wheelchair and they began clearing away and washing a few cups. Soon after this the person wanting the toilet asked again if someone would help them. One of these two staff told the person they had a pad on. When we asked this staff member if the person could be assisted to the toilet they told us the same answer. They stated they knew that it was not dignified for the person to have to use continence aids in this way. The person was not taken to toilet while we were present. This did not respect their dignity.

We recommend the provider ensures staff uphold people's dignity at all times.

We saw that one person was still in their nightwear in the middle of the afternoon, but when we asked them about it they clearly told us it was their choice and that they had not dressed for almost three years. Their preference had been respected all that time.

We saw that where people were able they maintained their independence of thought and deed. One person stayed in their bedroom and only came out occasionally for exercise, to take items back to their room for making a hot drink and to collect the newspaper or exchange a book. Others chose to occupy the lounges or to stroll around the grounds whenever they could. Those that smoked were assisted to do so in the garden. Other people were encouraged to be as independent as possible with dressing, eating and moving around the units in Brough Lodge and Elloughton House, which meant they had opportunities for self-esteem to develop.

Good

Is the service responsive?

Our findings

People we spoke with could not remember having care plans in place. One said, “I am never asked about contributing to my care plan, but I am asked to give my consent to care. My particular needs are usually met okay and my spouse visits every day so they make sure anything I need is dealt with.” However, visitors understood that care plans were available and said about making choices, “X can’t as they are mainly in bed and unable to speak”, “Y prefers to be in their room, eats there and everything” and “Z has no choice as they are unable to make any.”

We saw care plans in four people’s care files and found them to be appropriately completed and reviewed. Files contained photographs of people, a list of contents, pre-admission assessments, care plans with clearly defined sections, missing person forms, ‘Getting to Know You’ forms, ‘meet and greet’ information, behaviour charts, key worker details and evaluation forms. The care plans were divided into 12 sections that covered physical health, skin integrity, continence needs, mobility, communication, nutrition, personal hygiene, sleeping, social interaction, mental health, finances and other information. We saw that people had details of their needs for each of these sections, action plans for staff to know how best to meet the identified needs and reviews of actions and care requirements.

Regarding hobbies and interests people said, “There are few activities”, “There is nothing I like doing here”, and “We sometimes get entertainers visiting us.” Visitors we spoke with said, “There is a church service every three weeks and I think there is a singer once a week, who is very good”, “There are no activities as far as I am aware, but staff have occasionally taken Y to hear a singer, who is not at all bad” and “There are no activities.”

We saw that people were assisted to read newspapers or books, there were jig-saws to complete, music to listen to and television to watch. Some people were assisted to stroll around the gardens or take a walk to the local community shops and cafes if they were receiving one-to-one support.

We saw from staff meeting minutes in June 2014 that the service intended to provide more activity and to provide some sensory equipment for people living with dementia. However, we did not see any sensory sessions taking place and activities were few.

Visitors knew they could visit any time of the day or night, within reason and said, “I can visit anytime, and X’s daughters are involved in their care”, “I can make a full visit at any time and I am fully involved in Y’s care” and “I can visit anytime, I even call in at night to see if Z is okay.”

When we asked people about making complaints not all of them were aware of a complaint procedure or how to express concerns. They said, “I am unsure but I would tell my spouse. I’ve never made a complaint and don’t know if I’ve been told how I could make one”, “I would tell one of the staff if I were unhappy about anything”, and “Oh I would just tell them (the staff). We don’t stand on ceremony here.” Other people said they would talk to their relatives first.

Visitors we spoke with about making complaints told us they would “Go to the Manager" as they had been told they could do this in a relatives committee meeting, “I’d go straight to the manager, then ring the head office if not satisfied, though I have had no information about this” and “I'd see the manager, then talk to someone at headquarters, but no one has told me to do this.” One visitor said they had complained recently to the head office, and someone from there had arranged to meet with them at the service. They said the meeting had lasted about five minutes and then the person felt their concerns had been disregarded. We had not discussed this with the manager and so were unable to obtain the service’s response. However, we saw evidence that major complaints had been addressed using the service’s complaint procedure, investigations had taken place and responses had been sent to complainants. There were records of these complaints. There was no similar evidence seen for minor complaints. We saw that irregular audits on complaint handling had taken place and action plans had been produced to ensure the same issues did not arise again.

In January 2015 we were told in a notification that the service had been expecting to admit a new person following a planned move from another care service. Meanwhile the manager of Westerlands had carried out an assessment of a second person that day and the provider of that service had carried out the transfer of the person in

Good

Is the service responsive?

a hurry and before plans had been made to do so. Staff at Westerlands were led to believe the person that arrived unplanned was the planned admission. Staff soon realised that the person admitted should not have been admitted and the expected person was admitted later that day. The service informed the East Riding of Yorkshire Council safeguarding adults team what happened and then satisfactorily resolved the situation by sharing information with other organisations. The service ensured no harm was caused to either person.

We received information from the provider shortly after our inspection to explain that some of the staff at Westerlands had been commended by Yorkshire Ambulance Service for their excellent cooperative working. This was for assisting with emergency treatment to a person that was taken ill while out in the community. The message from Yorkshire Ambulance Service was 'Today your staff were on an outing in Hull. Sadly a resident was taken ill…I would like to personally thank the staff involved for their prompt actions, particularly a gentleman…who recognised and implemented lifesaving skills and assisted myself in regaining cardiac output in what were very difficult surroundings. Once again thanks to all those involved in giving the patient a fighting chance.' This was testimony to the service working cooperatively with other organisations.

These are two examples of where the service had cooperated well with other organisations during the transfer of people's care from one organisation to another or where responsibility for a person's care was being shared.

Requires Improvement

Is the service well-led?

Our findings

At this inspection we found there were concerns regarding record keeping. The information we received from East Riding of Yorkshire Council (ERYC) was in respect of care plan records not always being accurately updated to reflect people's needs. ERYC have been carrying out monitoring visits. We looked at the accident books for The Garden Suite, Humberside Court and a third book with no unit name on it. We found that the records kept on accidents hadn't always been completed thoroughly, as in the case of Humberside Court. There were three entries without a date and with section 3 of the record left blank. Records in this book were not systematically chronologically completed.

We found that monitoring charts were not always completed at the time the care or support was provided. We saw that people had positional change charts and food/fluid intake charts in their bedrooms. At 11:00 am, while in Elloughton House, we saw that the last entry on one person's positional change chart read 06:00 am. Staff came to assist the person to change position while we were in their bedroom speaking with their relative, so we left the room. The relative also left the room. When we and the relative returned to the bedroom and looked again at the chart it had been completed with a further three entries: 8.15 am, 10:00 am and 11:00 am. This showed that staff were not always completing monitoring charts at the time they completed tasks.

At 11:20 in 'Humberside Court' in Brough Lodge we spoke with one person who was still in bed. They said they did not want to get up as they felt poorly. They had a chesty cough. They said they had been given a drink and we saw a jug of juice on their bedside cabinet. We asked them if we could look at their intake chart and saw the last two entries were on 1 and 6 April 2015, with no entries in between those dates. There were no entries yet for 7 April 2015. This showed that staff sometimes omitted to complete monitoring charts. We saw that there were eight different staff on duty in 'Humberside Court' across the four days: 2, 3, 4 and 5 April 2015, according to the rosters we were given.

We found that recruitment files were sometimes lacking start dates, training details, nurse's personal identification numbers (PINs) and supervision details. We asked the registered manager to send us details of the trained nurses' PINs and their training records. Not all of this information has been received.

We looked at six staff recruitment files and saw that some of them had missing information; start dates for two staff, a full DBS check for one staff, no up-to-date appraisal for one staff (the latest appraisal recorded for them was 2008), no training details for one staff and no supervision records for two nurses. We were informed by the administrator that the two nurses were newly recruited to Westerlands. We saw from their files that one had started in November 2014 and the other had evidence that references had been received in October 2014.

We looked at the staff training matrix and staffing rosters, which showed there were some inconsistencies. There were four staff names missing from the training matrix that were listed on the staffing rosters. There were three staff names on the training matrix that did not appear on the rosters. This caused confusion and may not have enabled the service to accurately check which staff required updated training in the various topics considered to be mandatory or additional training. We found that training records were poorly maintained.

We saw that there were some discrepancies with medication records. We saw that one medicine (night time sleeping tablet stored as a controlled drug but not needing to be recorded as one) was recorded as 28 in stock on the MAR sheet, but as 35 on the controlled drug register. The MAR sheet was correct with the actual number of tablets available but the correct number had not been carried forward in the controlled drug register. This medication record discrepancy had no impact on the person receiving their medication.

When we looked at the MAR sheets in Brough Lodge we saw there was an instance where one drug stated 'take one a day', but on the MDS package it said 'take as directed'. There was no information to show if, when or why the administration instructions had changed, so the error may have been on the part of the dispensing pharmacist. The service had not identified this discrepancy, but there was no impact on the person receiving their medication.

We found that there were improvements required with regard to record keeping because the service had not always kept documents accurate or up to date.

Requires Improvement

Is the service well-led?

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this inspection report.

People we spoke with were unable to describe the culture or atmosphere of the service. One said, "I stay in my room so I don't know what it is like." Visitors we spoke with told us, "I feel a lot of residents aren't very happy", "I think it has been a bit depressive but I don't go out of my relative's room very often, so can't really say" and "Okay. When organised staff are on duty it's calmer, but when other staff are on it can be rowdy." We observed that there was a friendly culture in the service among the staff, but not all of the staff carried out their roles with regard to the consequences of their organisational skills. Staff were not working as a team, which led to some people having to wait for support.

There was a new manager in the service, registered in the last three weeks. The history at Westerlands in respect of registered managers is that there have been six registered managers and one unregistered manager over the last four years. This has not provided the people that use the service or the staff team with stability of leadership. We acknowledge that the new registered manager has worked at the service as part of the service's management team in the last two and a half years to provide support. This means they do know the service so their appointment is considered as positive and will lead to a consistent period of leadership.

The current registered manager showed an open and transparent style of management, but there were mixed views expressed to us regarding their approachability and availability. Comments from people that used the service, visitors and staff included, "I don't' know her as I have never met her", "I suppose they are (approachable), I never see the manager over here (Elloughton House)", "They (management) will listen and the manager runs an 'open door' on a Wednesday from 2pm", "If I see the manager she says all the right things", "I have phoned head office, but if I keep on complaining the staff might take it out on my relative", "The manager is approachable", "The manager didn't introduce herself to me. She's only spoken to me once and she stays in the office most of the time" and "Yes the manager can be approachable."

We saw that some people who received one-to-one support were able to go out in the community for a walk or to the local shops with their carer. We were told that some people went out with family members, to places of entertainment or to their home for tea.

There have been no changes to the registration of the service since the opening of the new building at Brough Lodge in early 2012, when the number of registered places increased from 35 to 62.

We were told by the registered manager that there was a quality assurance and monitoring system in operation that included carrying out audit checks on several areas of the service and seeking people's satisfaction levels about the care and support they received.

We saw that the service carried out audits on care plans, safeguarding systems, pressure care, diabetes, weighing people, infection control, privacy and dignity and complaints. These had last been completed between January 2015 and March 2015. We saw that the privacy and dignity audit did not have an action plan or draw any conclusions and the infection control audit was not effectively used as it had not made use of the percentage scores to show the outcome. The health and safety, care plan and the complaints audits did have action plans in place. We did not see evidence that quality audit information had been gathered and used to identify shortfalls in service delivery or improve the service people received, and there were no records of changes made.

However, we were shown a document that looked at all aspects of the service from the point of view of 'risk'. This was a monthly produced 'risk matrix' tool against the five Care Quality Commission 'domains' (safe, effective, caring, responsive and well-led). It showed which areas were identified for action within the service based on the 'likelihood and consequence' of risks from, for example, poor training, a registered manger not being in post, poor adherence to 'no secrets' and Prime Life procedures, lack of induction and supervision and an ineffective quality monitoring system. The matrix for April 2015 showed there was very low risk across the service in all of these areas and no risk in others. Action taken to mitigate risk was shown on the tool as and when completed and a forecast made showing the new risk following the action taken. There was

Requires Improvement

Is the service well-led?

additional information about the tool on how to assess the overall risk for the service and produce a summary document showing the levels of risk across a region covered by the organisation.

We were shown a new Prime Life 'annual quality assurance survey' to be issued to people and relatives containing nine questions to be rated one to four: 1 inadequate, 2 requires improvement, 3 good and 4 outstanding. This was to be issued as part of the quality monitoring improvements taking place. The last satisfaction survey issued to people that used the service and their relatives in June 2014 had seen some returns but information in these had not been analysed or an action plan produced. Therefore people and visitor's views that we obtained from speaking with them during our inspection could not be supported, contradicted or balanced with summary views and information the service had already obtained from a larger sample.

We saw there was evidence that 'resident / relative' meetings were held. The last meeting had been held in February 2015. Areas discussed included staffing, meals, activities, communication and care plans. Relatives' views were that staff needed to work more as a team and they thought 'good' staff didn't stay very long. They said meals were satisfactory but more variety could be offered to those on soft diets. Relatives said they had found it difficult to get hold of staff when they telephoned the service units directly, as opposed to when they telephone the main office number.

Staff meetings had also been held to seek information, but the last one documented was in November 2014. We judged that another meeting held since then would have ensured effective communication was maintained. Staff meeting minutes for June 2014 and November 2014 were provided for us to look at. We saw that attendee numbers were six in June (including the manager, clinical lead and administrator) and twelve in November (including the manager, associate director and administrator).

There was evidence in the June minutes that a range of positive and negative topics had been discussed and our inspection found some of these were on-going issues. We saw evidence in the November meeting minutes that all staff were informed of their obligation to attend training. Communication was discussed; in particular that senior staff must be informed when people that used the service had accidents and falls and that accident records must be completed. This meant that the service used meetings as part of the quality monitoring system to identify shortfalls in the service delivery and to instruct staff on what was expected of them.

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
	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People who used services were not always being protected from the risks of receiving inappropriate care and treatment because complete and contemporaneous records 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) were not always being maintained. Other records relating to the management of the service were not always being accurately maintained. 17(2)(d)(c)