Barchester Healthcare Homes Limited

Lindum House

Inspection report

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Date of inspection visit:
25 May 2016
26 May 2016

Date of publication:
05 July 2016

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 25 and 26 May 2016 and was unannounced. At our last inspection of the service on 12 September 2014 the registered provider was compliant with all the regulations in force at that time.

Lindum House provides both nursing and residential care for people over the age of 18, older people and people living with dementia or a physical disability. The service can accommodate a maximum of 64 people. The service is situated in the market town of Beverley. The accommodation is provided over two floors and most of the bedrooms have en-suite facilities. There is a range of communal rooms on each floor. There is on-site parking for staff, visitors and relatives and the home is accessible to people in wheelchairs.

The registered provider is required to have a registered manager in post and there was a registered manager at this service who had been in post since 2015. 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.

During this inspection we found that the home was not always safe. Risks to the health and safety of people using the service were not always thoroughly assessed and effectively managed and this placed people at risk of otherwise avoidable harm. This was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The recording and administration of medicines was not managed appropriately in the service. This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was insufficient support and supervision of the staff to ensure that issues raised during this inspection around staff competence, care practices and staff attitudes were identified and addressed by the management team. This had an impact on the quality of life for people using the service. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the majority of the time care and support was offered appropriately and in a friendly and helpful manner. However, we also saw some staff interactions that were carried out without thought or consideration of the people using the service. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People confined to bed for most of the day and others unable to move down to the ground floor for activities were receiving little or no stimulation and social interaction on a daily basis. This meant people were bored or spent their day sleeping. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Record keeping within the service needed to improve. We saw evidence that medicine records, care plans, risk assessments, turn charts and wound care records were not always accurate or up to date. This meant that staff did not have access to complete and contemporaneous records in respect of each person using the service, which potentially put people at risk of harm. This is a breach of Regulation 17 (1) (2) (a-c) of the Health and Social Care Act (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.

Improvements were needed to the number of staff on duty to meet the needs of people who used the service. People and staff commented that the levels of staff on duty fluctuated on a daily basis and this was also evidenced in the staff rotas. We have made a recommendation in the report about this.

People's nutritional needs had been assessed and they told us they were satisfied with the meals provided by the home. However, the dining experience of people living on the first floor of the service was task orientated and lacked interaction and communication. We have made a recommendation in the report about this.

The assessment and monitoring of diabetes and people with this condition was not robust. We found no evidence of risk assessments and care plans relating to diabetes in the care files we looked at. Some input from diabetic specialists was seen, but there was little evidence that staff were proactive with regard to recognising the special needs of people with diabetes. We have made a recommendation in the report about this.

Staff had access to adequate induction and training opportunities, but the percentage of staff receiving supervision, to assess and monitor their practice, needed to improve. We saw some very good interactions during our inspection, between staff and people, but we also saw areas of practice that could improve. This may have been recognised by the management team if staff were supervised on a more frequent basis. We have made a recommendation in the report around this.

The environment within the service was comfortable, clean and homely, but it was not particularly designed to be dementia friendly. Only a fifth of people using the service lived with dementia. However, improvements could be considered regarding the dementia design aspect whenever the service was refurbished or redecorated. We have made a recommendation around this in the report.

We found that some people who used the service had limited input to the development of their care plans and they told us that the care being provided was decided by the staff on duty rather than in accordance with their wishes. We have made a recommendation around this in the report.

People told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm and there were enough staff to meet people's needs. Staff had been employed following appropriate recruitment and selection processes.

People were confident about raising any concerns with the registered manager. We saw the registered manager investigated these and gave people a written response to their complaint.

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

Some aspects of the service were not always safe.

Risks were not always effectively managed and this impacted on the safety of people using the service. The recording and administration of medicines was not being managed appropriately in the service.

Improvements were needed to the number of staff on duty to meet the needs of people who used the service.

There were processes in place to help make sure the people who used the service were protected from the risk of abuse and the staff demonstrated a good understanding of safeguarding vulnerable adult's procedures.

Is the service effective?

Requires Improvement

Some aspects of the service were not always effective.

The assessment and monitoring of diabetes and people with this condition was not robust. People's nutritional needs had been assessed and they told us they were satisfied with the meals provided by the home. However, improvements to the dining experience of people living on the first floor of the service were needed.

Staff had access to adequate induction and training opportunities, but the level of staff support and supervision was not sufficient to ensure that concerns raised in this report about staff competence, care practices and staff attitudes had been identified and acted on by the management team. This impacted on the quality of life for people using the service.

The environment within the service was comfortable, clean and homely, but it was not particularly designed to be dementia friendly.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the service to be meeting the requirements of the Deprivation of

Liberty Safeguards (DoLS).

Is the service caring?

Requires Improvement

Some aspects of this service were not always caring.

The care and treatment of people was not always person centred, met their needs or reflected their preferences.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care plans did not always clearly describe their needs. We saw no evidence to suggest that people were not receiving the care they required, but judged that the care provided was not well recorded.

Some people had little or no access to stimulation or social interactions on a daily basis. This left people bored or sleeping most of the day.

People knew how to make a complaint and those who spoke with us were happy with the way any issues they had raised had been dealt with.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Record keeping within the service needed to improve. We saw evidence that medicine records, care plans, risk assessments, turn charts and wound care records were not always accurate or up to date.

People were given the opportunity to give their opinions and viewpoints of the service through the use of surveys meetings and face to face meetings with the registered manager. People who spoke with us recognised who the registered manager was and were confident that they would be listened to.

We found that there was a quality assurance system in place but it was not always effective. We found during our inspection that staffing levels, staff supervision, health and safety risks and medicines were being audited but we had concerns about these areas of practice, which made us question how effective the

audits were.

Lindum House

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 registered 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 25 and 26 May 2016 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector and two experts-by-experience on day one and one ASC inspector on day two. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts-by-experience who assisted with this inspection had knowledge and experience relating to older people and those living with dementia.

We looked at information we held about the service, which included notifications sent to us since the last inspection. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. As part of the inspection process we contacted the East Riding of Yorkshire Council (ERYC) Contracts and Monitoring Department and ERYC Safeguarding Team who informed us that there had been a recent monitoring visit due to concerns raised with CQC and shared with ERYC. A number of recommendations had been made in their report. We asked the registered provider to submit a provider information return (PIR) prior to the inspection and this was returned within the given timescale. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

At this inspection we spoke with the registered manager and the regional manager. We also spoke with six staff members and then spoke in private with seven visitors and 18 people who used the service. We observed the interaction between people, relatives and staff in the communal areas and during mealtimes.

We spent time in the office looking at records, which included the care records for five people who used the service, the recruitment, induction, training and supervision records for four members of staff and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe, if the staff assisting them had the right skills and if they felt the premises were safe and secure. Comments included, "Yes, staff are very helpful," "Yes, a lot of bodies about - they know what they are doing" and "Yes; you can close your doors, and the care staff are here morning and night." People also said, "I feel totally safe, I have a buzzer if I need anything and help comes if I need it" and "Yes, I like my own room, and my own company."

Visitors spoke with us about people's safety and said, "I have total confidence in the staff, they are so aware of [Name], I would recommend the home" and "Yes, [Name] cannot get out, staff keep an eye on them."

The registered manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed. We were given access to the records for accidents and incidents which showed what action had been taken and any investigations completed by the registered manager. However, not all risks within the service were being monitored and assessed appropriately. In the last three months before this inspection, CQC had received two complaints about the care in the service. One raised concerns about unexplained bruising on a person's wrists.

During our inspection we noted that one person had extensive bruising to their arms and legs. Discussion with the staff and the registered manager indicated that they were not aware of any reason that this person should be bruised in this way. We looked at their care file and medication records to see if there was an explanation for why they were bruised. We found this person was not on any medication that would increase their likelihood of tissue damage / bruising. Checks of the care file showed that the last fall this person had sustained was documented as January 2016 and that they had bed rails and bumpers in place on their bed. A member of staff had filled out a body map on 18 May 2016 documenting the person had a bruise to their right arm, a faded bruise to their left arm and bruising to both shins. However, there was nothing on the body map to say what may have caused this and there was no further information in their daily notes or care plans to indicate any investigation or action had been taken by the staff. Our observations of the person whilst talking with them indicated they had very fragile skin on all limbs. The lack of knowledge about the bruising, the poor recording of it and the lack of action taken to investigate the cause of it meant this person was at risk of further harm. We shared our concerns with the safeguarding team at the local authority.

This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people using the service if they understood what they were taking their medicines for. People told us, "Yes; I know what they are for," "Staff give me them and I take them" and "I have been told and understand." Only one person did not know what their medicines were for, which indicated that the majority of people had been able to discuss their treatment and care with staff and / or their GP. People responded positively when asked if they received their medicines on time, including pain relief medicines. They told us, "It is always on time; I never need pain relief," "The staff are pretty good, if I have got a pain they give me some tablets," "My medicines are sometimes a little later than other times, but usually within an hour – I am

happy with this and I do not get pain" and "Always on time, Paracetamol are available if I need them."

We observed one member of staff administering medicines in the service. Appropriate practices were used to check, administer and record the medicines given to people. The member of staff asked people if they required pain relief medicines and other medicines given on an 'as and when required basis'. Medicines that required storage at a low temperature were kept in a medicine fridge and the temperature of the fridge and the medicine room were checked daily and recorded to monitor that medicine was stored at the correct temperature.

The nurses and senior care staff informed us that they had received training on the handling of medicines. This was confirmed by our checks of the staff training plan and staff training files. We looked at a selection of medication administration records (MARs) and checked a random sample of medicine stocks held in the service. We found unsafe practices with regard to the ordering, recording and administration of medicines.

Controlled drugs (CDs) were regularly assessed and stocks recorded accurately. CDs are medicines that are required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. However, when we looked at the use by date on one CD we found that although it had been checked weekly the staff had not realised it was out of date. The CD had not been used, so the risk to the person prescribed it was low, but it brought into question the robustness of the medicine audit.

Topical medicine charts were in use for the application of external use creams and lotions. However, we found that staff were not always signing when they administered these. For example, one person had been prescribed a cream and we saw that staff had signed to say it had been applied on the day of the inspection. However, it had been in use for three days prior to the inspection and there were no other signatures on the chart. This meant we could not be certain that this was being administered appropriately and as prescribed.

One person had run out of their medicine, but staff had used the wrong code on the MAR indicating the person was refusing their medicine rather than the fact it was out of stock. This had eventually been recognised by the staff and the medicine was reordered, but we saw this meant the person did not receive their medicine for seven days. This could have had a negative impact on their health and wellbeing.

We saw that another person had gone without their medicine for four days because the GP had doubled the dosage due to the person's deteriorating health condition. Instead of staff giving two tablets twice a day the staff had stopped the person's medicine and recorded 'Wrong dose' from 16 May 2016 until 20 May 2016 when they received a new prescription from the pharmacy. We checked and found there were sufficient stock levels of the original tablets to have enabled the staff to administer the increased dosage, but staff could not say why they had not done so. This could have had serious implications for this person's health and wellbeing, but this fact had not been recognised by the staff administering medicines.

This was a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who used the service if they felt there were enough staff on duty and if a lack of staff ever impacted on their quality of life such as having to wait for care or not being able to attend activities. We also asked people what time they got up in a morning. The responses we received were a mix of both positive and negative comments.

Comments we received included, "The service have put a new system in and I think it is better (call bells) – I usually have to wait a few minutes for assistance" and "I usually get up between 08:00 and 09:00." "The staff

answer the call button fairly speedily," "Yes, there are enough staff on duty, they are always popping in and out, and I sit and talk to the hairdresser" and "Sometimes a bit pushed, no long waits - I am usually up by 09.30." "Sometimes I have to wait quite a while when I need to go to the toilet and it can be very worrying if you want to go straight away." One person told us, "No, there are not enough staff on duty, but it does not affect me as I am fairly independent. However, at lunchtimes I have to wait a long time for my meal." This person went on to explain that they went down to the dining room at around 12.00 but did not get their dinner until nearly 1pm.

At lunch time we saw that on the upstairs floor, people who required meals in their rooms were left waiting until 13:30 before being served even though they did not require any assistance from staff. The meal on the ground floor was also delayed. The registered manager told us that this was not usual practice.

Checks of the records held in the service showed that a dependency level tool was used by the manager to calculate the staffing levels required to meet the needs of people who used the service. We were given a copy of the tool used to calculate staffing levels in May 2016 and the manager said it would be reviewed as people's needs changed or numbers in the home went up or down. Information from the dependency tool showed that there should be one nurse on duty over the 24 hour period plus nine care staff on duty each morning, eight care staff each afternoon and four care staff at night.

At the time of our inspection there were 55 people in residence, 16 of whom required nursing care (29%). We looked at four weeks of duty rotas and saw that of the 28 days recorded only on seven of those days did the service have the stated number of staff on duty. On 11 days the service was short one member of staff on the morning and afternoon shifts and on others they worked at least one member of staff down over the two floors. This meant the service was not working to the levels indicated by the dependency tool. Staff told us, "It is improving, although it remains difficult at times" and "When everyone comes in to work there are enough staff to get everything done."

We recommend that the service uses the information from its dependency tool to ensure sufficient staff are always on duty to meet the needs of people using the service.

The registered provider had policies and procedures in place to guide staff in the safeguarding of vulnerable adults from abuse (SOVA). We checked the information we held about the service and looked at the safeguarding file in the registered manager's office. We noted that there had been no safeguarding alerts made in the last five months and this was confirmed by the registered manager. We spoke with staff about their understanding of SOVA. Staff were able to clearly describe how they would escalate concerns both internally through their organisation or externally should they identify possible abuse. Staff said they were confident their registered manager would take any allegations seriously and would investigate. The staff told us that they had completed SOVA training in the last year and this was confirmed by their training records. The training records we saw showed that there remained 17 staff (30%) who required refresher training in safeguarding adults. However, the training was on a rolling programme and these staff were due to attend training in 2016.

We looked at the recruitment files of four members of staff. Application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Interviews were carried out and staff were provided with job descriptions and terms and conditions. This ensured they were aware of what was expected of them. The registered manager carried out regular checks with the Nursing and Midwifery Council to ensure that the nurses employed by the service had active

registrations to practice.

We spoke with the maintenance person and looked at documents relating to the servicing of equipment used in the service. These records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment serviced included the fire alarm system and the nurse call bell, moving and handling equipment including hoists and slings, portable electrical items, water systems and gas systems. There was also an electrical wiring certificate in place that showed the electrics were checked every five years.

Clear records were maintained of daily, weekly, monthly and annual checks carried out by the maintenance person for wheelchairs, hot and cold water outlets, fire doors and call points, emergency lights, window opening restrictors and bed rails. These environmental checks helped to ensure the safety of people who used the service.

The registered manager spoke with us about the registered provider's business continuity plan for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met. Personal emergency evacuation plans (PEEP's) were in place for people who would require assistance leaving the premises in the event of an emergency. These were located in people's care files. Discussion with the registered manager indicated they were looking at putting these together in one file as part of the 'Grab and Go' equipment that staff used in an emergency.

Requires Improvement

Is the service effective?

Our findings

During our inspection we saw some very good examples of effective care practice, but we also saw some instances where staff practice could have been improved. People and relatives who spoke with us said that they had on-going treatments and assessments planned to meet their health needs, but we were not always sure as to whether these were being met and actioned by the service.

For example, one person was waiting for a motorised wheelchair assessment, but to date this had not happened as the wheelchair company were supposed to see them on the 9th May 2016, but did not turn up. The person's family had asked the service to assist, but the family told us that they felt that the staff did not care. We followed this up with the deputy manager who said one of the nurses had contacted the wheelchair company to arrange another visit date.

Another family told us, "We do not feel that [Name's] physical wellbeing is being met at the moment. Since the fall, they have lost their confidence and the service thinks [Name] will fall again so they have two staff to get them up. We think [Name] should be getting some help in re-building their confidence in walking otherwise it might be too late and they might never regain it. We have suggested to staff, that this should be happening but nothing has happened yet." The deputy manager assured us that if a person had lost confidence in walking then a referral would be made to the falls team and to a physiotherapist for additional input and support around mobility. We asked that any follow up actions by staff be clearly documented in the care files.

Two people whose care we looked at were diabetic. However, staff were not following best practice guidance and we found that their care files did not include specific risk assessments or care plans for diabetes. In one care file information about the person's diabetic needs was referred to in the moving and handling care plan and their nutritional care plan, but only briefly. This indicated that the monitoring and reviewing of their diabetic condition was not robust. However, this person had been seen by a diabetic specialist on three occasions in the last six months, which indicated some action had been taken with regards to their health and wellbeing.

We recommend that the service finds out more about current guidance on diabetic care and take action to update their practice accordingly.

The registered manager showed us the induction paperwork completed for staff in their first three months of employment. We found that the registered provider used the 'Care Certificate' induction that was introduced by Skills for Care in April 2015. Skills for Care is a nationally recognised training resource.

We looked at records of staff training to check that staff had the appropriate skills and knowledge to care for people effectively. We saw that staff had access to a range of training deemed by the registered provider as both essential and service specific. Staff told us they completed essential training such as fire safety, basic food hygiene, first aid, infection control, health and safety, safeguarding and moving and handling. Records showed staff participated in additional training including topics such as Deprivation of Liberty Safeguards,

Mental Capacity Act 2005 and equality and diversity. The registered manager told us "Some courses are computerised, some distance learning and some face to face."

We found evidence during the inspection that some appraisals and supervisions had been completed, but further work was needed to ensure all of these were brought up to date. The training plan we were given to look at indicated that six members of staff had not received supervision in the last 12 months and six others had last had supervision over six months before our inspection. During our inspection we found concerns about staff competence, care practices and staff attitudes, which have been documented within the five key question sections of this report. A number of these issues may have been picked up by the management team if staff supervisions had taken place on a more frequent basis.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to talk to health care professionals about their care and treatment. All individual health needs, visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken (as required). We asked people who used the service how easy was it for them to access their GP and other health care professionals and they told us, "I am hoping the GP is coming today," "I have not had to see the GP; I have seen a district nurse - I had daily visits for a while, but these are not needed at the moment" and "Yes, access to them is pretty good. The district nurse attends for my knee and I am going to see about another hearing aid." Other comments included, "Yes, the doctor came once; the chiropodist is six weekly" and "I can usually see a GP within a day and I see my own optician."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records showed that seven people who used the service had a DoLS in place around restricting their freedom of movement. Documentation was completed appropriately by the registered manager who displayed a good understanding of their role and responsibility regarding MCA and DoLS.

Staff had completed training on Mental Capacity awareness during the last year and were aware of how the DoLS and MCA legislation applied to people who used the service and how they were used to keep people safe. We saw in care records the service had taken appropriate steps to ensure people's capacity was assessed to record their ability to make complex decisions. People who spoke with us said that staff always asked them for their consent before carrying out care tasks. One visitor told us, "Yes, I am involved in my relative's care; we have just completed a Restrictions of Liberty Form for [Name]."

Staff used established, evidence-based strategies and techniques to support people. For example, care staff were trained in the use of the DICE (Describe, Investigate, Create, Evaluate) tool for communication in people with dementia. This is a four-part tool used as an empowerment strategy to help caregivers reduce

the instances of or anxious behaviour in people with dementia.

From looking at records we saw staff used this tool to support people in specific areas of need such as personal hygiene, continence, mobility, tissue viability, nutrition, breathing and pain management. Staff were also trained in the use of non-violent intervention techniques to manage and support people with aggressive or violent behaviour that challenged. When people displayed particular behaviours that needed to be managed by staff in a specific way to ensure the person's safety or well-being, this information was recorded in their care plan. Two staff told us that restraint was not used within the service. Staff told us, "We know their triggers and use distraction techniques and talking to calm them down."

Visitors told us they were happy with the level of communication between themselves and the staff. They said, "Yes, every time I visit they tell me how [Name] is" and "Yes, the staff keep me up to date." We asked the staff to describe how people were supported to make their own decisions and choices in daily living. They told us, "We give them choices of meals, drinks, what to wear and where they want to spend their time," and "Everything should be up to them. We ask them what they would like us to do and how, and then do our best to carry this out."

Entries in the care files we looked at indicated that people who were deemed to be at nutritional risk had been seen by dieticians or the speech and language therapy team (SALT) for assessment on their swallowing / eating problems. We asked people if they had a choice of meals and if they required any assistance with eating or drinking. People told us they were all independent with eating and drinking and said, "Very good choice of food and plenty of it," "Generally very good, I like breakfast best, porridge and drinks" and "Good choices, I get a menu and my favourite is bread and butter pudding." Other comments included, "Pretty good food, as good as it can be when cooking in bulk, choice of two meals always" and "The food is good, always get a choice, I get my breakfast in bed (by choice)." Visitors were also pleased with the meals provided and told us, "[Name] likes the food, it is portion suitable, [Name] likes salmon and it is always set out nicely and they get a glass of wine" and "Very good, menus good, [Name] says it is lovely."

We spoke with the Chef who said all food was prepared on site. They got a list of likes / dislikes from the nurse or senior in charge when a person arrived, and they showed us a file in the kitchen with every person's dietary requirements. A sheet accompanied the food each day so staff knew what to serve to whom. Diabetic foods included low sugar jellies, fresh fruit and an artificial sweetener was used in some cooking. The kitchen was open 24 hours a day, and food was always available. The chef advised us that there were two choices always at meal times, with a further menu to choose from if these were not liked, which included omelettes and jacket potatoes.

Observation of the two units showed that people had very different dining experiences. On the ground floor the lunchtime meal was a lively affair. People were asked where they wished to sit and care staff chatted with people as they gave them drinks and assisted people to the table. People were asked if they required assistance with cutting up their food and staff gently encouraged people to eat more if they were hesitant during the meal. The food looked appetising, was appropriately sized and hot. We overheard people saying, "This turkey is lovely" and "The pudding is great."

However, on the first floor we observed that during the meal, staff made little effort to talk to individuals, choosing to talk amongst themselves about personal / home life. The atmosphere was 'joyless' with no chatting between staff and people and no background music. We noted that half way through the meal, one person in an armchair had fallen asleep but staff did not take any action what so ever, just leaving them to sleep with their lunch on the table going cold. Staff told us that only four people ate their meals in the dining room and everyone else preferred their meals in their bedroom. We looked at the meals being served to

people in their bedrooms; this was a very slow process with some people not being served until 13.30 even though they did not require assistance. We saw one person trying to eat their own meal which had been placed on their over-bed table. They seemed to be having some difficulties as quite a lot of the food was around their mouth and chin. We did not see any staff checking on their progress or assisting them.

We recommend that the service considers carrying out observations of the dining experience within the service, with a view to improving the mealtimes for everyone using the service.

We saw that the environment within the service was comfortable, clean and homely. People told us they had no problems navigating around the service and that there was plenty of room for them to move around with their walking aids such as wheelchairs and walking frames. The service had accessible outdoor spaces, where people could enjoy the sunshine and fresh air as and when they wanted to. Discussion with the regional manager indicated that the entrance area of the service was due to be refurbished to create a café style facility, but no date for this had been reached with the registered provider.

There were some dementia design aspects to the service, but these were very low key such as the odd picture on the bathroom doors to show what the facility behind the door was, plain carpets in the corridors and neutral colours on the walls. We appreciate that only 12 people using the service had a diagnosis of dementia, which was 22% of the total people in the service. However, we would recommend that the service consider current guidance on dementia friendly environments whenever they carry out a refurbishment or redecoration of the facilities.

Requires Improvement

Is the service caring?

Our findings

During the inspection we observed interactions between staff, people and visitors. We found the majority of the time care and support was offered appropriately and in a friendly and helpful manner. However, we also saw some staff interactions that were carried out without thought or consideration of the people using the service.

For example, after lunch we heard one person calling out and went to investigate. This person was in need of urgent personal attention. There were no care staff around so we pressed the call bell for them. A male carer came immediately, but told us that as there were only two male care staff on the floor, they were not able to give personal care to the female service user. The female nurse on duty was busy administering medicines and could not assist them. The staff made no effort to seek assistance from the other unit and it was only when the inspector asked a female member of staff for help did this person receive the care they needed. Ten minutes after our initial request for help, the person received the necessary support from two female members of staff. Our concerns about why the unit was left without both male and female cover and the lack of response from the staff was fed back to the registered manager who spoke with the staff on duty.

The majority of people on the ground floor who spoke with us said they felt the staff had the right skills to meet their needs and were caring, but there were some who felt better care could be given. Comments included, "I would like more baths but I never ask," "They ask me what I want" and "Very caring, they show concern for me." One visitor told us, "I feel that [Name] has to wait a long time for the toilet at times, but overall I have no problems with the support and care given to [Name]. Another visitor said, "The staff have a genuine affection for the people they are looking after and I am very happy that they do their best."

However, people on the first floor told us a different story. Comments included, "I think they do their best under pressure. I think they do very well, it is very rare that you hear people being told off and they speak to me with respect." "Yes, I am looked after alright but would like to be treated like an adult. Quite a lot of the time I can be really desperate to go to the toilet and am told that there isn't anyone available to assist me. I really have to hold myself and I would feel really upset if I had an accident. Some days staff can be very pleasant and other days they can't be bothered" and "It depends what mood they are in, sometimes they will help you and have time for you and sometimes not." Two people said, "They just walk into my room and get me washed" and "You are told when to go to bed, even if you are in the middle of watching TV or reading."

We asked further questions of people and visitors about the quality of care being given and we were told, "I need two carers to assist me and sometimes it takes a while for them to come as it depends on what else is happening and if they have the time to come to me." One person told us, "I don't like being in this particular home as I don't like being told what to do, decision are made for me. For example, my idea of going to bed is to have a proper wash or bath, I like to be nice and clean. I am not allowed to go to bed by having a nice wash or bath, I am just undressed by the care staff when they come into my room and say 'We will put you to bed now', as if I am a small child, I feel old enough to decide when I want or need a bath." Another person said, "I don't have the chance to ask for anything, they come in and say to me that they are going to wash

me and I have told them that I don't want them to, but they tell me I am going to be washed."

We gave feedback to the registered manager and the regional manager at the end of our inspection about the different opinions of people and visitors regarding the staff attitudes on the units. We were given assurances that these would be investigated and the staff spoken with at the next general meeting.

This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

We asked people how well the staff communicated with them and they told us, "Staff have a natter with us off and on all day," "We have a chat during meal times in the lounge, if I don't understand anything I will ask them to explain." Others commented that, "The staff come around, but they have a lot to do," "We have a chat any time, for example when they are getting me up and at bedtime" and "Lunchtimes mainly; some are genuinely interested in me."

The registered provider had a policy and procedure for promoting equality and diversity within the service. Discussion with the staff indicated they had received training on this subject and understood how it related to their working role. People told us that staff treated them on an equal basis and we saw that equality and diversity information such as gender, race, religion, nationality and sexual orientation were recorded in the care files. Staff also supported people to maintain relationships with family, friends and other people in the community.

Discussion with the staff revealed there were no people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

We observed how staff promoted people's privacy and dignity during the day by knocking on bedroom doors prior to entering, ensuring toilet and bathroom doors were closed when in use and holding discussions with people in private when required. People told us, "The majority of staff are very good. They always knock on my door before entering – it is the home's policy," "I get embarrassed with some things and I like to do them myself" and "They put you at ease and you can relax when they are with you." One visitor was pleased with the way staff interacted with their family member. They told us, "Yes, they know [Name] does not like being touched and now they have encouraged [Name] to let the staff bath them."

We asked people if they felt they were kept informed about what went on in the service and they all mentioned the monthly newsletter and the weekly list of activities. One person told us they also received information from the resident meetings. For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available in the entrance hall of the service. People told us they did not use independent mental capacity advocates (IMCA) as they were either capable of speaking up for themselves or had a member of their family who acted in this capacity for them. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

Requires Improvement

Is the service responsive?

Our findings

Assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. Each person had their own care file, which contained a number of care plans. We looked in detail at five of these files. The information recorded within this system was person centred. Records evidenced that the information had been gathered from the person themselves and their family.

We asked people and family members if they had been involved in the care planning process and we received a mixed response from individuals. One family member told us that no-one had asked them about their relative's care needs or things that were important to them. They had not been involved in developing a meaningful care plan and to date (nearly two weeks) no one had spoken with them or updated them with regards to how their relative had settled in. One person who used the service told us, "I have not been asked about my care preferences, they just have decided how to care for me, and they haven't asked me any questions." Three people who used the service were not sure if they had a care file or not but two others were more positive and they told us, "I have one (care file), and my relative has had consultations with staff" and "We discussed my care needs when I first came in and my care plans have been reviewed."

We recommend that the service seek advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their care, treatment and support.

We looked at five care files during this inspection. We found that people's care plans did not always clearly describe their needs. We saw no evidence that people were not receiving the care they required, but noted this information was not well recorded. We found it difficult to read some of the notes in the care files due to the quality of the staff handwriting. We asked staff if they could tell us what some notes said, but they were unable to decipher what was written. This indicated that some information about people's care and support was illegible; this would make it difficult for staff to deliver continuity of care.

For example, one care file documented that the person using the service had been seen by their GP in May 2016 and a discussion had been held with their family and staff to decide on their future care. An agreement was made that the person would receive 'palliative care', which included four hourly pressure relief, removal of their catheter, administration of analgesia 'as required' for pain relief and there were to be no further hospital admissions. However, when we looked at their care plans we found these had not been updated since the decision for palliative care had been made and therefore they were no longer relevant to the person's current needs. For example their continence care plan still referred to their catheter, but when we checked with staff they said this had been removed. The pressure sore prevention plan made reference to two hourly 'turns' when in bed. Checks of the pressure relieve charts recorded by the staff showed there was a mix of two and four hourly turns taking place, indicating staff were not sure which plan to follow.

One care file contained information about wound care. We saw that staff had completed a wound care plan made up of a wound care regime section that spoke about the dressings being used to clean, cover and heal the wound and how often these were to be changed. There was also a treatment plan that detailed the

appearance of the wound, such as size, odour, colour and when it had last been attended to. We saw that staff had changed the type of dressing twice since starting the treatment plan but the regime had not been updated. The frequency of dressing changes had also been increased, but again the regime plan did not reflect this. This would make it very difficult for a new nurse or a bank nurse to give continuity of wound care as the care plan was not up to date and did not reflect the current care being given. However, we found that staff had made appropriate referrals to the GP and the community tissue viability nurse when needing advice or guidance about the wounds.

Please see the well-led section of this report for the action taken regarding records.

We spoke with the two activity co-ordinators working within the service. One co-ordinator worked full-time Monday to Friday and the other was part-time and also carried out hairdressing sessions within the service. They held monthly resident meetings to find out what people using the service wanted to do. Recent activities included bingo, quizzes, excursions, coffee mornings at a nearby supermarket store, movie club and one-to-one sessions. One activity co-ordinator was asked about dementia friendly activities and they said they had passed the Dementia Awareness Level Three training. They were involved in gathering people's life histories and speaking to families to ensure they understood people's backgrounds and what was important to them.

People's religious needs were met with a monthly visit from the vicar of Beverley Minster, and the holding of a monthly Christian Service. We saw the monthly newsletter and a weekly activity calendar which were circulated around the service. There was also an activities board on display showing the weekly activities available, but this did not include times for one-to-one activities. On the ground floor we saw that in the morning six people were watching an old black and white film in the lounge with a care staff in attendance. At lunchtime ten people in the lounge were reading newspapers and interacting with the activity co-ordinator and at 12:20pm staff asked quiz questions and people answered and laughed a lot.

People we spoke with on the ground floor said, "I have been out on the Westwood and to a café; I don't mind a quiz" and "I go to the church services if I want." "They have quizzes, entertainers in, and we have religious services and I attend them," "Movie afternoon today, someone reads to us and we have a quiz" and "I like my own company, I get library books."

People told us their family and friends were made welcome and there were few restrictions on visiting. Comments we received included, "They can come anytime and are made welcome," "Daughter comes every day" and "Always offered tea and biscuits." Two visitors told us, "The staff prefer you not to visit across mealtimes." The registered manager explained that too many visitors at lunchtime put some people off eating their meals.

On the first floor people were less satisfied with the activities available to them and there was little going on during the day for them to join in with. From our observations it was clear that the service was almost divided in two with regards to atmosphere and entertainment opportunities. People who were not able to get out of bed had little opportunity for stimulation or activities based on one-to-one needs. This was evidenced by the two people left sleeping in the lounge all day. Whilst we were on the upstairs floor all day, we did not see any one-to-one time or activities taking place. The atmosphere on this floor was depressing and lacked joviality. There was no stimulation for people other than lying in bed watching television all day. We were told that some people were occasionally taken downstairs to join in with the activities taking place, but this excluded the majority who were confined to bed. One person said "They don't come and talk to me, they just leave the television on for me to watch all day." Another person told us, "I don't think staff have the time to do the things I want to do like go to the shops. I go downstairs occasionally, but because they have

to have two staff to hoist me, I can be downstairs for longer than I want to be because I have to wait until they are available to take me back to my bedroom." A third person said, "They take me downstairs to watch the movies, if you don't go there is nothing else to do."

This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People knew how to make a complaint and those who spoke with us were happy with the way any issues they had raised had been dealt with. One person told us, "I would go to the person in charge or my family member, I did complain (couldn't remember subject) and it was put right." Other people commented, "If I wanted to lodge a complaint I would see the registered manager, but I have not had to," "I would see [registered manager], no complaints" and "I would tell my keyworker, no complaints, but laundry does gets a bit mixed up at times." Visitors told us, "In the first instance I would speak to [Name's] keyworker then the office - happy with all the staff" and "I would see [Registered manager] - no complaints."

We saw that people had access to a copy of the complaints policy and procedure; this was available in a small print format which may not have suited the needs of everyone using the service. Discussion with the manager indicated they could provide people with a larger print version on request. Checks of the complaints folder showed the registered manager had investigated seven complaints in the last six months. All the complainants had received a written response to their concerns and the issues were now resolved.

Requires Improvement

Is the service well-led?

Our findings

We found that there was a quality assurance system in place but it was not always effective. We found during our inspection that staffing levels, staff supervision, health and safety risks and medicines were being audited but we had concerns about these areas of practice, which made us question how effective the audits were. We noted issues with the dining experience of people using the service and the involvement of people in compiling their care plans. These areas were judged to have a minor level of risk to people using the service and a low impact on people's health and wellbeing.

Record keeping within the service needed to improve. We saw evidence that medicine records, care plans, risk assessments, turn charts and wound care records were not always accurate or up to date. This meant that staff did not have access to complete and contemporaneous records in respect of each person using the service, which potentially put people at risk of harm.

This was a breach of Regulation 17(1) (2) (a-c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was a registered manager in post who was supported by a deputy manager and an office administrator. People who spoke with us all knew and claimed to get on well with the registered manager. They told us, "I could talk to them, but no need to at the moment," "Yes, I find them approachable," "[Name of registered manager], I think they are approachable" and "The registered manager and I get on very well."

Staff told us the service was well led. One member of staff said, "Feel I get a lot of support, the registered manager's door is always open - always feel listened to." Staff told us that they were confident about talking to the registered manager and felt that things would be kept confidential when possible. Comments included, "If something was serious I would definitely whistle blow" and "I feel [registered manager] would listen to me and I would feel comfortable talking to them. We have a whistleblowing help-line which is confidential and it would be dealt with in a professional manner."

Feedback from people who used the service, relatives and staff was obtained through the use of satisfaction questionnaires, meetings and one to one sessions. The satisfaction questionnaire information was gathered and analysed by an independent company (Ipsos MORI) and given to the registered provider; where necessary action was taken to make changes or improvements to the service. Every person who spoke with us said they had not completed a survey although a number of people were aware these took place.

The 2015 survey report showed that 100% of people who took part in the survey were happy living in the service and 100% were satisfied with the overall standard of care. However, responses from relatives (19 received) were given as 83% and 89% for the same questions about their loved ones in the home. The results from the relative's survey echoed some of the concerns raised in this report when assessed against the national average scores. There were lower than average ratings given for people being treated with kindness, dignity and respect; people being encouraged to live independent lives; staff having time to talk and there being enough staff on duty. Other areas where ratings dipped below average included, relatives

having the opportunity to be involved in care decisions, staff appreciating relative input about care, special food needs being met and relatives having the opportunity to comment on the running of the home.

We saw meeting minutes that showed resident and relative meetings took place throughout the year. We were given a copy of the minutes for the family and friends meeting on 20 April 2016 and the residents meeting held on 21 March 2016 when ten people attended. Two people told us, "I go, but just to listen and go along with the flow" and "I go but can't think of any improvements I want making to the service."

We were given a copy of the registered provider's vision and values for the service. The information indicated that the service would inspire, empower, enable, engage and support with honesty. Feedback from people, visitors and staff indicated that the service did follow this remit to some extent, but not equally across the service. The registered manager said they were aware of some issues and they were working on improving the service through staff training and development. The registered provider had introduced a 'Resident of the day' principle where staff focus would be on one person each day, looking at care, health and safety, hygiene and cleanliness, nutrition and social activities. However, we found that this had not been implemented fully and needed further work to succeed. The registered manager also spoke about the implementation of a 'You said, we did' notice board, where people would be informed about what action had been taken in response to their feedback. We saw that this was in the early stages of development.

We saw that the registered manager completed a month end report to the registered provider. This showed they analysed risks within the service and reported on these to the registered provider. Monthly audits were also completed and those for April / May 2016 showed that any issues were put onto action plans and dealt with by the registered manager. However, there remained some areas of the service that could be improved. We found that there were two different approaches to care and support within this service, one was much better than the other, with those people who required nursing care receiving a more clinical and stark experience than the residential clients. We observed some very good care practices in the service, but also found evidence that some people received care and support that did not meet their needs or wishes. The findings of our inspection were fed back to the registered manager and the regional manager at the end of day two of our inspection. They assured us that action would be taken to improve the quality of care across the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider failed to ensure that people who used the service received person centred care that was appropriate, met their needs and reflected their personal preferences, whatever they may be. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of people using the service were not always thoroughly assessed and effectively managed and this placed people at risk of otherwise avoidable harm. Regulation 12 (2) (a) (b) The registered provider failed to protect people against the risks associated with the unsafe use and management of medicines by the inappropriate arrangements for recording and handling of medicines used for the purposes of the regulated activity. Regulation 12 (1) (2) (g)

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

personal care Treatment of disease, disorder or injury	governance People were not protected against the risks of inappropriate or unsafe care and treatment because of ineffective operation of quality assurance systems to identify, assess and manage risks relating to the health, safety and welfare of people who used the service. The registered provider failed to maintain an accurate record of care and treatment in respect of each person using the service. Regulation 17 (1) (2) (a-c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider failed to ensure staff received appropriate support and supervision to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)