Boroughbridge Manor Limited

Boroughbridge Manor and Lodge Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 18 and 19 March 2015 and was unannounced. We last carried out an inspection on 19 June 2014 where we found the home was meeting all the regulations we inspected.

Boroughbridge Manor and Lodge is a residential care home for older people, some of whom are living with dementia. The home can accommodate up to 76 people over three floors and is located in the town of Boroughbridge. The registered provider is Avery Boroughbridge Limited.

There was a manager in charge of the home who had only recently commenced in post but had not yet submitted their application to be registered to the Care

Summary of findings

Quality Commission. 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.

A new care planning process was being implemented which had resulted in a lack of, or inconsistent information recorded about how people's needs were to be met. Specific areas of risk had not been assessed and addressed appropriately and this placed people at risk of harm.

Although there appeared to be sufficient staff available, their deployment and additional responsibilities were not well organised. This meant the number of staff available to provide direct care and support was reduced and this impacted on people's care

Staff had received training with regard to safeguarding adults and they were able to tell us what they would do if they suspected abuse had taken place.

People received their medicines at the times they needed them. The systems in place meant medicines were administered and recorded properly.

Some staff had received training with regard to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. However we found some areas of practice did not take into account people's mental capacity and best interests.

There was a staff training programme in place, however, further training was required to ensure staff had the specialist skills and knowledge to provide care for people living with dementia.

People had their nutritional needs met. People were offered a varied diet and were provided with sufficient drinks and snacks. People who required special diets were catered for.

People had good access to health care services and the service was committed to working in partnership with healthcare professionals.

People told us that they were well cared for and happy with the support they received. We found staff approached people in a caring manner. We found that most of the time people's privacy and dignity was respected. However we observed some incidents where people's dignity was not respected and these were reported to the manager.

A lack of robust care planning impacted on people's health and wellbeing. Care plans lacked information or contained contradictory information for staff to provide care and support in manner which responded to the person's needs consistently.

People knew how to make a complaint if they were unhappy and all the people we spoke with told us that they felt that they could talk with any of the staff if they had a concern or were worried about anything.

People and their relatives completed an annual survey. This enabled the provider to address any shortfalls identified through feedback to improve the service.

Changes to management arrangements had impacted on the service provided. There were good auditing and monitoring systems in place to identify where improvements were required and the service had an action plan to address these.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe.

A failure to assess and respond to risk placed people at increased risk of harm.

There were insufficient staff available to meet people's needs safely.

The systems in place to provide people with their medicines were safe and effective.

Is the service effective?

Requires improvement 

The service was not effective.

Staff received training relevant to their role, however staff were not appropriately trained in providing support to people living with dementia.

The provider had appropriate policies and procedures in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However these principles were not always applied appropriately in line with legislation and guidance.

People were provided with a choice of nutritious food. Snacks and drinks were available at any time. People's dietary likes and dislikes were known by the staff.

The home had developed good links with health care professionals which meant people had their health needs met in a timely manner.

Is the service caring?

Good 

The service was caring.

With some minor exceptions which we reported to the manager, people's privacy and dignity was respected and staff were kind and attentive.

People were well cared for and appeared at ease with staff. The home had a relaxed and comfortable atmosphere.

Is the service responsive?

Requires improvement 

The service was not responsive

We found people's needs were not being assessed sufficiently. There was inaccurate, conflicting information recorded in care plans which resulted in some people not having their needs met.

We found staff lacked the skills and understanding in providing up to date dementia care.

The provider responded to complaints appropriately and people told us they felt confident any concerns would be addressed.

Summary of findings

The provider actively sought the views of people and collated them in the form of an action plan to improve the service.

Is the service well-led?

Requires improvement

The service was not well led.

The manager was new in post and as such had not had sufficient time to fully implement improvements identified through the provider's monitoring and auditing systems. However they had a clear vision about what was required and the standard of service they wanted the home to deliver to people.

There were opportunities for people who used the service to be involved in determining how the service was run.

Boroughbridge Manor and Lodge Care 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 and 19 March 2015 and was unannounced.

The inspection was carried out by two inspectors, a specialist professional advisor with expertise in providing nursing care and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During our inspection we carried out observations of staff interacting with people and completed two structured observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were not able to talk with us.

We undertook this inspection sooner than we had planned because we had received concerns about the management of the home and concerns about the health and welfare of people living in the home. This information helped us plan our inspection.

During the inspection visit we reviewed seven people's care records, three staff recruitment files, records required for the management of the home such as audits, minutes from meetings and satisfaction surveys, medication storage and administration records. We also spoke to the manager and the regional manager; eleven members of staff including, registered nurses, care staff, activities organiser and kitchen staff. We also spoke to two visiting health professionals, eight people who lived at the service and five relatives.

Inadequate

Is the service safe?

Our findings

We found that the service was not safe.

The manager explained a new care planning format was being introduced and the service was in the process of transferring old care plans on to the new document. We found examples that this process was placing people at risk of harm. Care plans were disorganised, and contained large amounts of paperwork which was not current and relevant. Information was not placed in chronological order. This had the potential of causing delays in identifying documents to assist staff in providing safe and appropriate care. For example we found a body map document for someone detailing the presence of a skin tear on the person's right hand. However, other documentation relating to this identified problem could not be located. We also found conflicting details on documents. For example, a body plan of a person stated the person was admitted from another care provider with a pressure sore. However the admission sheets stated that the person's skin integrity was all intact on their admission to the home. This meant the person may not have received appropriate care.

We found that risk assessments regarding direct care were limited and did not entirely measure the risks that could affect service user safety and wellbeing. An example of this was that we could not find any evidence to show that a risk assessment outcome to refer to a specialist service had been followed through to ensure that the person was being managed appropriately and in a manner that would protect them from harm. On highlighting this to the manager, they were not sure if the referral had occurred but assured us that this issue would be immediately followed up.

For another person their nutrition care plan indicated they liked finger foods, sandwiches and biscuits; that they were to be offered a high calorie diet and they needed to be weighed on a weekly basis. Their assessment indicated that they were to take a minimum of 1040mls fluids on a daily basis. We identified that food and fluid charts were not sufficiently detailed for us to determine whether this person was receiving sufficient food and fluid as advised. We also noted from records this person had lost weight. However staff told us they had not kept a separate record of food and fluid because this person 'Ate really well.'

There was a system to record accidents and incidents however the system to report and review had the potential to delay appropriate action being taken in a timely manner due to the multi person involvement of each incident report. In the event of an incident, a staff member would complete a paper copy of an incident plan. This included the person's details and a summary of the event with any immediate actions taken. The paper form was then sent to the administration staff who, during office hours, entered the details of the incident on to a Datix System. This was then electronically allocated to the home manager for review and management. We followed an incident report through the system in order to gain a better understanding. We chose a random paper report which detailed someone who had fallen and injured their face. The fall was unwitnessed. The carer had fully completed the sections of the form and the administration staff had documented the Datix number on the form (this alerts the manager that the incident had been entered on to Datix). However the manager was unable to access the system in order to assess whether the incident had been addressed appropriately and had to wait for the regional manager to access the system.

We witnessed a carer who inappropriately transferred a person from a wheelchair to an armchair in an unsafe manner which had potential to cause physical harm to both parties. A relative told us they had also observed unsafe practice in transferring a person and was concerned about the level of staff training in this regard. This was raised to the manager as a high risk concern.

We observed one person given a bowl of very hot porridge. This person made several attempts to eat the food and a staff member warned them it was very hot but they walked away and left the person to eat. Our observation indicated this person did not have the capacity to understand the information the staff member had told them and consequently they were at risk of scalding themselves.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was one main entrance to the building which was secured by a key code. The front desk was continually

Is the service safe?

staffed by a member of administrative staff during office hours. Outside of these hours entry for visitors was by call bell. There was a secure garden for people to access independently.

We asked people their views on the safety of the building. One commented "Well I sleep soundly as I know that I am safe as the staff are all here". Another person commented "I have never thought about it really. That tells me that I am safe." The third person reported "No worries on that point, safety is very high here". We spoke to five members of staff and asked them how they applied safety measures in the building. Comments included "It's a constant practice that we do as we are working, such as making sure windows are closed".

A visiting relative told us "(name) is safer here than at home. I think they've coped with (name) remarkably well". And "Yes I feel (name) is safe".

There were risk assessments in place relating to the safety of the environment and equipment used in the home. For example hoisting equipment and the vertical passenger lift. We saw records confirming equipment was serviced and maintained regularly. The service had in place emergency contingency plans. There was a fire risk assessment in place for the service and personal emergency evacuation plans (PEEPs) for individuals.

The home was in the process of being refurbished and redecorated. We noted a lack of risk assessment and planning relating to the safety of people. Areas of the home were not cordoned off safely and there were risks relating to trips and hazardous substances. Staff said there were no risk assessments in place for the work being undertaken although some people had been moved to other floors during the day to reduce the impact on them. No one on 'Forget Me Not' unit had been moved despite people on this unit living at advanced stage of dementia. We observed the decorators were working around people and although pleasant in their manner we did not see any particular safety measures being taken. Pots of paint and equipment were clearly potential tripping hazards. At lunchtime people were seen sitting in an alcove behind a barrier of furniture which appeared to have been done to give themselves some privacy whilst they took their own lunch undisturbed.

Most people we spoke with thought there were usually enough staff on duty but there was concern about staff changes and the subsequent lack of continuity and the impact this had on communication with people and relatives. One relative told us "Changing staff here is a huge problem. Sometimes I don't see anybody. If I do, I hardly ever see the same person twice. It's been like that for years. I get the feeling they'll recruit anybody". Another relative was also concerned about too many staff changes and said that there was no permanent member of staff on the unit where their relative was. They also felt that this affected communication because staff did not get to know people when they were put on different units each day.

Another relative told us they had observed "Fraught situations" arise at the end of the day and questioned whether it was fair to ask staff to work 12 hour shifts. They said they noticed towards the end of the day both staff and people who lived at the service were tired. They wondered if extra staff could be present at what they described as these 'hot spots' of time when additional patience and understanding was required.

Other people told us that they felt they, or their loved ones, were safe in the home. However, one relative said although they felt their mother was mostly safe, they had observed their relative and several other people in a lounge one day for 40 minutes without any staff present. They also mentioned that sometimes when they visited they did not see any staff at all.

We spoke with the manager about how they determined staffing levels and deployed staff. They told us they had a staffing dependency tool, Care Home Equation for Safe Staffing tool ("CHESS"), which they completed and this determined how many staff were required. The tool used a scoring system relating to the needs of individuals. The manager explained care staff were supported by ancillary staff such as hostesses who worked in the dining areas and supported staff in ensuring people were provided with regular drinks and snacks and served meals. The manager also confirmed that a number of staff had left as a result in the change of management at the home and there was a concentrated effort to recruiting new staff currently.

Although there were sufficient staff allocated to be on duty we observed staff were often engaged in non-care related tasks which meant there were fewer staff available to provide direct care to people. For example the local doctor came into the home to hold a home visit surgery. They were in the home from 2pm until 8pm; during this time a member of staff was assisting them and was therefore not

available to provide care to people. Additionally staff told us during their 12 hour shift they had two fifteen minute breaks and a half hour break. This meant for the unit where four staff were on duty, for four hours during the day the unit only had three staff available.

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Which corresponds to Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014

The service had policies and procedures with regard to safeguarding adults and whistleblowing . When we spoke with staff about their responsibilities for keeping people safe they referred to safeguarding polices and confirmed they had received training about safeguarding adults. They were able to explain the process to follow should they have concerns around actual or potential abuse. Although the manager had not been in post long there was evidence which demonstrated a commitment to working in partnership with the local authority safeguarding teams and they had made safeguarding alerts appropriately.

We looked at the recruitment records for three staff and found they had all completed an application form. We did note that for two of the records the application forms were dated as the same date as the interview. The manager told us this was because people had been invited for interview following information received via a recruitment agency. Application forms included details of former employment; however for one of the forms the previous employment had been listed but not the dates. This meant the provider was not able to verify whether there were any unexplained gaps in employment. All applicants had attended an interview. Two references and DBS (previously criminal records bureau) checks had been obtained prior to the member of staff starting work. This process helped reduce the risk of unsuitable staff being employed.

Although most areas of the home were clean, there was a noticeable smell of urine on the top floor and we observed crumbs on the floor of a lounge in the middle of the day which looked as if they had been there for some time. We also noted the small servery on the ground floor dining room had damaged flooring and was dirty. We saw food items on the work top and dirty jugs had been left on the radiator top.

We saw staff had access to personal protective equipment such as aprons and gloves and we observed staff using good hand washing practice. However, on touring the building, we noticed some poor infection control practices including a lack of clinical waste bags throughout the building and commodes stored in bathrooms. One relative told us they had concerns about the level of cleaning in their relative's room as they had noticed crumbs at the edges of the carpet and bits of food dropped under the bed and left for weeks. They confirmed they had raised these concerns and it had been addressed satisfactorily. Another relative told us they had taken their relative out for lunch one weekend and on return their relative's room had not been cleaned. They questioned whether there was adequate domestic staff cover at weekends. We spoke with the manager about the cleanliness of the home and they confirmed there had been issues with the standard of cleaning but these had been addressed through the staff capability process.

We checked the systems for the storage, administration and record keeping with regard to medicines. Medicines were located in a locked clinical room in a lockable trolley secured to the wall. There was also a lockable medicines fridge. The member of staff explained that medicines were supplied in a monitored dosage system with pre-printed medication administration records (MAR). Medicine boxes were colour coded to indicate morning, lunchtime or evening doses. We completed a random check of stock against MAR charts and found them to be correct. We saw controlled drugs were stored in a suitable locked cabinet and we checked stock against the controlled drugs register. The stock tallied with the record.

We noted that where people were prescribed PRN (as required) medicines, information was recorded about the circumstances under which the medicine could be administered.

Staff were not permitted to administer medicines until they had completed medication training. The training included a written exam and observation of competency which meant people could be assured they received the medicines they were prescribed safely.

We noted it was almost lunchtime before the home took delivery of medicines ordered yesterday as a result of the doctor's visit. This meant that some frail, elderly people seen at 2pm or shortly thereafter had waited almost 24 hours before they received essential medicines such as antibiotics. We spoke to the manager about this matter and they confirmed they were reviewing the effectiveness of their current dispensing pharmacy arrangements.

Requires improvement

Is the service effective?

Our findings

The service was not effective.

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty, these are assessed by professionals who are trained to assess whether the restriction is appropriate and needed. The manager did confirm when they had started in post people had not had their mental capacity assessed (MCAs) in order to determine the person's capacity to make decisions. They had therefore attempted to complete them as soon as possible. They manager acknowledged they had not been completed robustly and they had completed them generically rather than with reference to capacity on individual areas of decision making. We found that the MCAs were poorly documented and lacked supportive information around the decisions in applying the given level of current capacity of individuals. We saw in one person's file the mental capacity assessment did not include the names of people carrying out the assessment or job title, qualification or signature on each page as specified on the form. There was contradictory evidence as to who would act on the person's behalf and neither of those individuals had been included in the assessment process or were identified as having legal right to act on the person's behalf. Whilst reviewing people's care plans we identified areas of potential deprivation; however the mental capacity assessments completed did not reflect these. All of the assessments looked at related to the same issues; consent to have photographs taken, sharing information and medicines management and did not appear to relate to specific and individual needs.

This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The manager was able to demonstrate an understanding of the recent supreme court ruling which had clarified the notion of deprivation of liberty for people living in a care home setting. They told us they had made five applications for deprivations of liberty safeguards; one had been granted and the remaining four were awaiting a decision from the local authority. We reviewed the approved deprivation and saw the appropriate processes had taken place and reviews were scheduled.

Staff we spoke with all understood the need to support the rights of people who have been deemed as having reduced mental capacity and that part of their role was to support people's freedom and independence as far as possible. Service users were able to move freely around the building and we witnessed a carer supporting a person who wanted to walk in the garden. This person did not want to come inside and we observed staff respect this person's wishes but frequently went outside to encourage them to come inside because they were concerned the person was getting cold. When they refused staff provided a blanket to ensure they were kept warm and returned to them regularly.

There was a provider wide training department with specific staff employed to support staff training needs. Some staff from the home undertook 'Train the trainer' training in order to deliver in house training, for example in the area of moving and handling. Training was provided in video, learning books and face to face classroom type training. The manager told us the provider was moving towards reducing the amount of e learning as they felt it was less effective. Staff we spoke with told us that although training was effective and relevant to their job role there had been some gaps in providing updates recently. The manager confirmed this and was able to show us a schedule to ensure staff caught up with out of date training. It was noted, however, that moving and handling training had been cancelled during our visit as the trainer was required to work in the home due to staff shortage.

We spoke with the regional trainer who was visiting the home on the second day of our inspection. They told us they were responsible for coordinating training events in conjunction with the home's manager. We discussed what specialist training was available to ensure staff had appropriate skills and knowledge. We were particularly interested in training around provision of dementia care as the home's statement of purpose indicated this service was provided. They told us there was specialist training available but were unsure which model of dementia care this was linked to. Current good practice guidance linked to the national dementia strategy and the prime minister's challenge recommends services have clear vision about

models of dementia care. The trainer confirmed they did not have any knowledge of either strategy. We fed this information back to the manager and regional manager who confirmed they were aware of the need to provide more specialist training improve the quality of dementia care provided. We saw evidence that this was identified on the home's improvement plan.

We spoke to a member of staff who had recently started at the home. They told us they had been appointed a mentor to refer to and had the opportunity to shadow more experienced members of staff as well as completing a three day induction which had covered fire safety, health and safety, safeguarding adults, moving and handling and dementia awareness. They confirmed they had further training booked with regard to care planning, first aid and mental capacity. They told us the induction had been useful in helping them with their new role.

The manager confirmed that when they had started in post staff had not been receiving regular one to one supervision. Staff also confirmed this but said they had now started to have these meetings. We looked at some supervision records and saw a standard format with headings for discussion including the organisation's values, 'make every moment matter', 'keep it simple', 'do it from the heart', 'choose to be happy' and 'sort it'. The manager told us the intention of supervision was a two way process to enable staff to develop professionally and provide high quality care and support. This meant that staff were well supported and any training or performance issues identified.

We reviewed people's experience of mealtimes. We observed breakfast; staff had a pleasant, open manner with people and saw people were offered a choice which included cereals, porridge and full English breakfast. People appeared to enjoy their meals and no one was rushed.

We observed the lunchtime experience on all three floors and noted the tables were set with flowers, cloths and napkins and a menu for the day was on each table. We observed people seemed to enjoy their food which was presented attractively and was clearly hot. On the middle floor we noted that people were seated 45 minutes before the meal was served and some people were agitated by this. People were offered a choice of menu and the cook put a sample meal on two small tea plates for staff to show to people, enabling them to make a choice about what they wanted for lunch. We noted the cook knew people well and encouraged people to eat. They spoke quietly and reassuringly and we observed that someone with a sight impairment responded immediately to their voice and ate their meal. Whilst serving the meals the cook kept up a commentary telling people what was for lunch and including them in the conversation while speaking individually to people "Here, your dinner is ready for you, its pork and I know you like pork."

People's individual preferences were respected with one person having salad. However one person requiring a special diet had to wait a long time while others on their table were eating before their meal was served. One relative told us their relative preferred healthy food and this was provided with salads and yoghurts.

Those people who needed it were given discrete assistance with eating their meal and we saw people using adapted cutlery and plate guards in order that they could be independent when eating their meals. We saw that food was served on white crockery. Research suggests that coloured crockery encourages people living with dementia to eat. The manager told us they had ordered new coloured crockery.

The cook told us that potatoes and gravy was fortified with cream. They said no one on the top floor needed a soft diet but they always included a choice that was "Soft and mashable" because some people preferred that type of food and found it easier to eat. They were aware of people who needed special diets for health needs.

One relative told us "We've got some excellent cooks". And another person told us "The food is lovely here."

We saw people provided with snacks mid-morning and mid-afternoon which looked appetising. This included bite-size pieces of fresh fruit being offered as well as home-made cakes. This meant people had a choice of snacks which were easy to eat independently.

During this inspection the care records we looked at included a section titled catering requirements and included details of people's likes and dislikes and whether for instance they preferred to eat their breakfast in their room. We saw those people who had nutritional risks associated with their health and well-being had a

Requires improvement

Is the service effective?

nutritional risk assessment completed. We saw people had been referred to dieticians and speech and language therapists, however there was not always a clear audit trail to confirm the action taken.

We had received concerns from health care professionals that staff had a lack of understanding of people's health needs and in what circumstances to refer people. Consequently the manager had met with the local GP surgery, district nursing and ambulance services to resolve difficulties. At the time of the inspection all parties reported improvements in effective working relationships resulting in more timely and appropriate referrals.

A weekly GP surgery was held at the establishment on one afternoon each week. People who had been identified as needing to be seen by the doctor were added to a list that was faxed to the GP practice the day previous to the planned surgery.

Staff reported that this worked really well and avoided contacting the doctor's service directly. We asked about the process for people needing to see a doctor on other days. They reported that the surgery is contacted and a home visit is requested

We spoke to the visiting doctor regarding their experience and view of the care that was given at

the home. The doctor reported their confidence in the high level of care which was provided by the staff. They reported that there was a concerning shortage of staff some months back and felt that the standard of care had not been affected due to the commitment of the staff. The doctor reported that they had noticed a recent increase in staffing levels and was confident that the improved standards of care would be maintained.

The manager advised us that they had good support from the Community Psychiatric Nurses in terms of advice and management of changing needs of service users.

The home was purpose built which meant it was fully adapted for people with physical disabilities. There were communal lounges and smaller lounges for people if they wanted a quieter area to sit in. The home was being decorated and refurbished during our inspection. The manager told us the provider had consulted up to date guidance on providing a supportive environment for people living with dementia using light, colour and signage to assist with orientation and spacial awareness. However, there was a lack of reminiscence items to attract people's attention and encourage them to occupy themselves. We observed a cabin trunk with reminiscence items stored such as handbags and dolls, which could have been on display however these were not made available to people because the trunk was closed. We saw white boards outside the dining room with the intention to help people with the day date and season recorded, however this was showing the wrong date and day. We noted there were handrails to assist people to walk independently, and appropriately fitted grab rails in toilet and bathrooms. There was ramped access to the garden areas which had seating areas for people to rest and enjoy the garden.

We tested a call bell for a person who was in bed. Although this was cancelled away from the point of call a member of staff did attend. They apologised immediately for cancelling the bell and said it was not something they would usually do. They told us staff were instructed to wait and cancel the bell when they attended the person. This meant that if they had been waylaid on their way to the room the person's call may have gone unanswered.

We recommend that the provider reviews best practice guidance from the national dementia strategy in the provision of care for people with dementia.

Good

Is the service caring?

Our findings

The service was caring. People we spoke with were complimentary about the care they received. People told us "The staff are lovely, really nice, caring." and "It's very good, it has a homely feel. The staff are great without exception. The team are great. The staff try to do everything they can to meet name needs." Another person said "They're very kind and caring. I can't complain about anything. We're kept informed about things. I'm quite happy. I think they do their best. They're all quite kind and amiable."

Some people who had complex needs were unable to tell us about their experiences in the home. So we spent time observing the interactions between the staff and the people they cared for. Our use of the Short Observational Framework for Inspections (SOFI) tool found staff interactions were positive and benefited people's wellbeing.

We spent time in the lounge areas of the home. Staff approached people in a sensitive way and engaged people in conversation which was meaningful and relevant to them. We saw that staff acted in a kind and respectful way and people looked well cared for and appeared at ease with staff. The home had a relaxed and comfortable atmosphere. We saw that staff crouched down to talk to people at eye level and they spoke at a pace that was comfortable for the person. Staff seemed to know people's individual preferences and we heard staff referring to people's individual interests.

We saw staff had regard for people's dignity. For example we heard a member of staff suggesting to someone they wore a clothes protector during lunch. They referred to how lovely the person looked and that wearing the protector would make sure they remained that way. We also heard a member of staff gently advising they were adjusting clothing to preserve their dignity.

We observed a member of staff knocking on a person's bedroom door; they waited for a reply and tried to persuade the person to come into the dining room for lunch. This person was concerned about other family members but the member of staff handled their confusion very well by acknowledging their perceptions and reassuring them in a kind and considerate way.

We did however, observe a very small number of staff using inappropriate language for example calling people 'darling' in a condescending manner; referring to people as 'wanderers' and discussing people's personal needs in front of them and making comments about their behaviours in a derogatory manner. We fed this information back to the manager who told us they would address our concerns with the relevant staff.

Our observations indicated that people were able to spend their day as they wished. We saw some people involved in communal activities and others preferring to spend time in their rooms. One person told us they liked to spend time in a small lounge because it was quiet and they could watch the horses in a neighbouring field.

During the two days of our inspection we observed visitors coming and going; they were offered a warm welcome by staff. We were told there were no restrictions on visiting.

There were sections in the care plan document which related directly to peoples' choices and preferences. For example there was a section titled 'My typical day.' And a document titled 'My life story'. We discussed the importance of life history details in assisting staff to connect with people, involve people in activities which have been previously enjoyed and in providing reassurance if people became distressed. However some of these were not completed fully.

We saw people's bedrooms were personalised with their own furniture and possessions or family photographs.

We were told people had access to an external advocacy service if required and the service promoted an open door policy for people and their relatives. We were told for people at end of life care, the service would engage people and/or their relatives in advanced decision making which covered peoples expressed preferences and choices for their end of life care. The advanced decision making would consider areas such as equipment, specialist services (such as palliative care) and refusal of treatment. Staff told us they had received training with regard to providing end of life care. The doctor in particular commented on the high quality of end of life care the home provided. We saw there was a section within the care plan to address people's end of life care needs and preferences. We did see one record

Good

Is the service caring?

where the person's preferred place of death had not been recorded. NICE (National Institute for Health and Care Excellence) best practice guidance suggests this should be included.

Requires improvement

Is the service responsive?

Our findings

The service was not responsive.

The manager explained a new care plan format was being introduced with some care plans having been transferred and some not. We reviewed seven care plans during our visit; two sets of new care plans, three sets in the transitional stage and two sets from the previous model. The quality of care plans posed a potential risk that inappropriate care would be provided due to the lack of organised and consistent information. We spoke to a manager from another service who told us their role was to support the new manager and review and update care plans; transferring the information onto the new documentation. They were completing this task without reference to people, their families or other health care professionals. This method of completing care plans excluded the involvement of people who knew the person best and did not therefore put the person at the centre of their care.

One care plan that we looked at from the old model, showed that the person began to live at Boroughbridge Manor in June 2014. However, a large part of their admission assessment had not been completed. This posed a potential risk as the service did not hold a baseline of the person's health and wellbeing on admission, meaning that they had no reference point to rely on in the event of concerns, complaint or changes in the person's needs. Furthermore, the omission of unfinished admission assessment went against the provider's in house admission criteria that states "All admission assessments should be completed within six hours of admission". We were unable to find any evidence explaining the delay in this document completion.

We reviewed one person's care plan and spoke to a member of staff about this person's needs. They were very knowledgeable about this person and had helped them complete a very detailed life history. They explained the person could refuse personal care despite needing support in this area. The member of staff talked to us about the approach they used to ensure this person's needs were met. None of this information was recorded in the person's care plan and the staff member told us when they were not working the person's personal care needs were not met.

We observed an individual entering other people's bedrooms and moving personal items. We looked at this person's care plan. A generic risk assessment had been completed which indicated that this person was a risk to others because they entered their rooms without permission. We found that the action that was specified did not relate to the risk assessment as it only referred to the person's ability to have a key to their own room. We saw a mental health review had been undertaken in November 2014 where it was noted that staff were struggling to meet this person's needs and to manage the risk of falls and retaliation from others when they were invading their space. The care plan instructed staff to complete 30 minute observations, ensure handrails were accessible and that an 'alert' mat was in place at night. There was no assessment which attempted to analyse and understand this person's pattern of behaviour, how to alleviate it or direct it in a manner which reduced the risk of harm. This placed the person and other people at continued risk and demonstrated a lack of understanding in providing person centred care.

We were advised that District Nurses regularly visited to manage wounds and administer insulin.

However, District Nurse care notes were kept on the top floor and not with care plans which caused fragmented record keeping. The manager acknowledged this observation and assured a review of care record storage.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There were reports of two people with healing pressure ulcers. We reviewed both of their care plans which reported that pressure ulcers had developed whilst both people were living at Boroughbridge Manor. We found appropriate management strategies had been applied including referral to the District Nursing team, skin integrity checks, and pressure relieving mattresses.

The manager told us about plans to operate a 'Resident of the day' to review people's care. This meant that on 1st of the month the person in room one would be reviewed and on 2nd room 2. The review was intended to be a 'Whole

Requires improvement

Is the service responsive?

person' review with all staff departments contributing. So, for example, housekeeping and kitchen staff would be involved and with the focus on each person's whole experience within the home.

Our experience of activities on offer was very different over the two days of our inspection. On the second day an American miniature horse visited people on all three floors and singers entertained people with vintage songs during the afternoon. We also observed staff instigate a ball throwing activity aimed at maintaining physical hand eye coordination. These events were very popular with people and they appeared to really enjoy them.

However on the first day we did not observe any organised group activities. We were told this was because one of the activities organisers was occupied elsewhere. During the day we observed people sitting in the lounges with little staff interaction. Activity materials were not obviously available for people to instigate activities independently however we did acknowledge some areas of the home were in the middle of refurbishment with decorators on site. Therefore materials may have been put away while this was happening.

We spoke to the activities organiser who told us they worked full time but that half to three quarters of their time was taken away from their activity organiser role because of shortage of staff and their staff training role, which meant their work was disjointed. They told us there were two activities organisers employed and they usually played dominoes or did crosswords with people who lived on the ground floor and the other activities organiser did activities on the remaining two floors. They told us they knew what most people wanted but could not produce any evidence that people had been consulted about their interests or there was a mechanism to gather feedback on effectiveness of specific activities. We discussed what other activities they might provide but they said health and safety issues had to be considered "We can't just put out board games – can't be responsible for those things." We asked what they meant and they said "You put things out one day and find everything in pieces." We discussed specific activities recommended for people living with dementia such as reminiscence or life story work but they said they had not arranged any of this type of activity. They told us they had access to a local charity minibus so they organised trips out. People were reported to enjoy trips to Scarborough, and other local attractions.

We asked people what activities were on offer. One person said "I do nothing much at all." Another relative told us the only activity they had seen was bingo but that, since their relative has never liked bingo, they did not participate. Another relative told us they felt activities were 'on hold' because of the refurbishments.

We found that the service had a Complaints Policy in Place and that all staff we spoke with knew how to advise people on how to make a complaint. People told us they would feel confident in raising concerns with managers or staff. One relative we spoke with confirmed they had raised concerns, which were dealt with immediately.

We looked at the complaints log and saw the home had received six complaints. All were recorded with details of investigation and the outcome reported to the complainant. All were resolved to the satisfaction of the complainant.

The provider completed an annual survey of people who used the service and their relatives to gather feedback on all aspects of the service provided. Survey questionnaires were confidential and analysed by the provider's quality team. Results were published and with appropriate action plans put in place in response. For example the home's current refurbishment plan resulted from comments from the most recent survey.

Requires improvement

Is the service well-led?

Our findings

We spoke with the regional manager and the manager about recent changes in the management arrangements at the home. The regional manager shared with us areas of concern they had identified and we saw evidence of how the provider was managing this in the monthly audits completed prior to the new manager starting. As a consequence to changes in management a number of staff had left, including the deputy manager. The new manager advised us they had been in post for four weeks and were being supported by a manger from another service and the regional manager, to implement improvements. The manager told us they had a clear vision of how they wanted the home to improve, with a stable staff team who had the necessary skills and experience being a priority. They also wanted to review and improve the quality of care plans. The manager said they were still getting to know the home and the people who lived there. They said they tried to ensure they completed a daily walk around to speak to people and pick up any issues.

We spoke with two people about their views of the manager. One commented "I haven't a clue who the manager is" and the other said "I think there name is xxx but I have never met her". However, we spoke with a visiting relative who reported that they knew who the manager was and that they needed commending for the improvements that they had made to the service. They said "It doesn't go unnoticed".

Since the new manager has been in post there had been one relatives and residents meeting. Some of the relatives that we spoke with had attended but one who did not, thought that these meetings were a waste of time and a box-ticking exercise. Another relative told us they had not raised any concerns at the meeting but spoke to the manager afterwards. And another relative said "When I've asked for anything it's been done".

The manager advised us they had been made aware of concerns raised by the district nurse and local doctor's surgery and had met with them and the Yorkshire ambulance service with the aim of improving systems for referrals and working relationships. We were party to the minutes of these meetings. We also spoke with representatives from the district nurses and the surgery who confirmed improvements in working relationships.

Some of the staff we spoke with did not want to give comment regarding the management due to the short time in which the manager had been in post. However, some did say that they had noticed positive changes in terms of improved staffing levels and one member of staff commented that they thought the manager was fair and that they listened to staff views.

The manager explained there were a range of quality assurance systems in place to help monitor the quality of the service the home offered. This included formal auditing, meeting with senior managers and talking to people and their relatives. Audits ranged from regular daily, weekly, monthly and annual checks for health and safety matters such as passenger lifts, fire fighting and detection equipment. There were also care plan and medicines audits which helped determine where the service could improve and develop. Audits confirmed some of the issues we had identified during the inspection.

Monthly audits were also undertaken by regional managers which facilitated managers and staff to learn from events such as accidents and incidents, complaints, concerns, whistleblowing. This reduced the risks to people and helped the service to continuously improve. We saw from monthly audits that issues highlighted were being addressed, for example, the quality of housekeeping and arrangements for staff to receive up dated training.

Staff meetings had been held at regular intervals, which had given staff the opportunity to

share their views and to receive information about the service. Staff told us that they felt

able to voice their opinions, share their views and felt there was a two way communication

process with managers. We saw this reflected in the meeting minutes we looked at.

The manager ensured notifications required had been completed and sent to the CQC in a timely manner.

Overall we felt there were good management systems in place to monitor and ensure a high standard of care delivery however the number of outstanding issues needing to be addressed placed added pressure on the current management structure. We were informed that the recruitment of a deputy manager was a high priority and that this post would be supernumerary from the rota. This would assist in prioritising and addressing required

Requires improvement

Is the service well-led?

improvements as currently the manager was trying to deal with too many issues at any one time. We feel that this in itself placed potential risk on the everyday management and care delivery of the establishment.

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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Which corresponds to Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Which corresponds to Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 The registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to the care and treatment provided for them in accordance with the Mental capacity Act 2005 and the deprivation of Liberty safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Which corresponds to Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 The registered provider did not ensure there were sufficient numbers of skilled and experienced staff deployed to ensure the safe delivery of care.