Barchester Healthcare Homes Limited

Stamford Bridge Beaumont

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

Summary of findings

Overall summary

The inspection took place on 27 February, 12, 13, 18, 19, 26, March and 6 April 2018 and was unannounced apart from the final date when feedback was given to the provider.

Stamford Bridge Beaumont is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 107 people across five separate areas, during this inspection 59 people were living at the service.

There was a manager employed by the service, and they were in the process of registering with the Care Quality Commission. Following this inspection the managers application for registration had been accepted. 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.

At the last inspection in September 2017 we found the provider to be in breach of eight of the Health and Social care Act 2008 (Regulated Activities) 2014 in Regulation 9 Person centred care, Regulation 10 Dignity and Respect, Regulation 11 Need for consent, Regulation 12 Safe care and treatment, Regulation 13 Safeguarding service users from abuse and improper treatment, Regulation 14 Meeting hydration and nutritional needs, Regulation 17 Good governance and Regulation 18 Staffing.

The overall rating for this service is 'Requires Improvement' and therefore the service will be remaining in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from

operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found during this inspection that the provider had met the breach for Regulation 14. Improvements had been made but not sufficiently to meet the requirements of Regulations 9, 10, 11, 12, 13, 17 and 18.

We also identified one breach of the Care Quality Commission Registration Regulations 2009. This related to the failure to notify us of other events and incidents which had occurred at the service which the provider is legally required to inform us of. We will deal with the notification issue outside of this inspection process.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Effective and Well-led to at least requires improvement.

Care plans and risk assessments were not always aligned. There was a lack of guidance for staff around specific health conditions and how best to support people.

We saw many positive interactions between people and their relatives, but this practice was not consistent throughout the home. Some staff had little time to offer one to one interactions with people and those more isolated in their rooms had not received regular meaningful interactions.

People attended and enjoyed the group activities. The service had employed a mini bus driver to ensure regular outings in the community were arranged. However, there was a lack of stimulating activities and interactions for those people living with dementia or isolated in their bedrooms. Both staff and health professionals raised concerns around the lack of stimulation for some people living at the service.

People were not always supported to have maximum choice and control of their lives. The principles of the Mental Capacity Act (MCA) 2005 were not always fully understood by staff and the correct process for making decisions in people's best interests had not always been followed or documented appropriately.

Staff deployment across the service did not always take into account staff experience and skill mix to meet the dependency levels of people living at the service. During busy periods people did not always received the care and support they needed in a timely way. Staff were recruited safely and any gaps in support filled by agency staff, the numbers of agency staff had decreased since our last inspection during the day shifts but were still at high levels during some evening shifts. The manager told us they were focusing on this area to make improvements and had requested consistent agency staff to improve continuity for people.

Some medicines had not been managed well. We saw poor practice in the administration of one toxic medicine. As and when required medicines for pain relief were not always being monitored to ensure they were effective. Record keeping in some areas such as topical medicine charts was poor and in some cases creams had been used more than prescribed and others were unclear as to whether people had received their creams as prescribed.

Risks to people had not always been identified or managed appropriately to mitigate risks.

Staff had raised safeguarding concerns which had not been reported to the local authority or CQC.

Accidents and incidents and the actions taken were not always recorded at the time of the event happening.

Activity records were not detailed to include the time spent with people during any one to one periods and notes indicated some interactions may have been brief due to a lack of information.

People at risk of dehydration or malnutrition received an improved level of support from staff. Refreshments were seen to be given throughout the day and night to promote people's nutrition and hydration needs. Although we did see issues where fluid charts were inconsistent: they had not been totalled and no recommended amounts had been recorded. It was felt this was more of a records issue which the provider began to address during the inspection. The manager told us they had started contacting GP's for each individual's recommended daily fluid intake to ensure improved monitoring of people's hydration.

People and their relatives knew how to make a complaint should they wish to do so. Although there were facilities for staff to raise whistle blowing concerns anonymously, despite these being in place some staff felt unable to utilise the whistle blowing procedure to raise their concerns.

The provider had numerous quality assurance systems and audits in place which identified areas that required improvements to be made. However, some of the issues found during this inspection had not been highlighted through the providers own auditing and monitoring systems. The audits lacked content and detail in some areas. For example: feedback had been gathered from relatives, people living at the service and staff, but no records reflected those that had been spoken with, the questions asked or answers obtained. During the inspection process the provider acknowledged that improvements would be made to capture this additional information.

Improvements had been made to the decoration of the premises, neutral colours had been used, spa baths introduced to create a sensory experience and near the reception a hairdressing salon and bistro type coffee area had been developed.

People enjoyed the food which looked nutritious and well presented, pureed sandwiches were available which were suitable for those with difficulty swallowing. Finger foods were also offered to people. The chef was knowledgeable about people's dietary requirements and was aware of how to fortify diets and drinks to ensure optimum nutrition for people.

Positional changes had been completed in line with recommendations and hourly observations were being completed for all people living at the service.

Servicing and maintenance of the environment including fire safety and lifting equipment had been completed and certificates were current.

The overall rating for this service is 'Requires Improvement'.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Staffing levels across the service had improved with less use of agency staff overall. However, deployment of staff in areas where people's dependency levels were higher needed to be reviewed during busy periods so that their needs were met in a timely manner.

Some staff felt their concerns were not listened to or adequately addressed.

Risk assessments were not consistent. Some contained detailed information and others had no information around specific health conditions or guidance for staff on how best to support people.

Medicines had not always been managed safely and infection control measures needed to be improved.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider had not always followed best practice guidelines around gaining people's consent. Best interest decisions were not always in place to support decision making processes.

People's needs had been assessed prior to admission, but appropriate care plans for specific conditions were not always in place. In addition some records contained contradictory information which could be confusing for staff.

Nutrition and hydration practices had been improved. People were offered regular snacks and drinks throughout the day and night.

Staff training was regularly refreshed and new training had been introduced. However, some staff lacked knowledge in certain subjects and some felt training had insufficient practical elements.

Supervisions were inconsistently completed and follow up actions were not always actioned to develop staff.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We saw many positive interactions between staff and people living at the service. However, we did see some issues around promoting people's dignity.

Relatives told us that people were left unsupervised to wander in and out of other people's rooms - observations confirmed this was happening on a regular basis.

Staff had good awareness of the importance of promoting peoples independence and supported people's choices and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans contained some person centred information to guide staff, but others were task based and lacked information and guidance for staff to follow.

Group activities were enjoyed by the people living at the service and plans were in place to utilise outdoor areas. However, stimulating and meaningful activities or interactions were lacking for those people that were isolated in their bedrooms or living with dementia. Staff and health professionals felt that more could be done to improve in this area.

People and their relatives knew how to complain if they needed to and the majority felt confident that their concerns would be addressed. In some instances complaints had been reviewed and a lesson learnt form completed to guide staff when dealing with similar situations in the future.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had quality assurance systems in place to drive improvements within the service. However, these did not identify some of the concerns raised during the inspection. Following the last inspection the provider had submitted weekly actions plans to CQC. These showed some improvements had been made, but lacked supporting evidence.

Accidents and incidents had not been recorded in a timely manner to include actions taken to mitigate risks to people.

Notifications had not always been made to CQC and the local authority in relation to safeguarding incidents and allegations.

Stamford Bridge Beaumont

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over seven days from 27 February and ending on 6 April 2018. The inspection was unannounced with the exception of the final day which was announced to ensure the provider was available to receive our feedback. Day three was completed between 8.30pm and 11pm. This out of hour's visit was in response to concerns raised by relatives and due to our concerns at the previous inspection. We discussed all these concerns with partner agencies including the local authority safeguarding and quality monitoring team.

On day one the team was made up of one adult social care inspector completing telephone calls to staff. Day two consisted of one adult social care inspector, a specialist advisor who was a registered general nurse with clinical and dementia knowledge and a pharmacist inspector. The team on day three were one adult social care inspector 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. On this occasion the expert had knowledge and experience of working with older people and those living with dementia.

The out of hours visit on the fourth day consisted of two adult social care inspectors, the fifth visit was carried out by four adult social care inspectors, the sixth visit by three adult social care inspectors and seventh visit by two adult social care inspectors. The final day was attended by one adult social care inspector and an inspection manager, feedback was delivered to the provider during this visit.

We reviewed information we held about the service, such as notifications we had received from the provider and information from the local authorities that commissioned services with them. Statutory notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service.

We asked the provider to submit a Provider Information Return (PIR) prior to the inspection. This is a form

that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with seven people who used the service, seven relatives, three unit managers, five nurses, five senior care workers, fourteen care workers, two activities co-ordinators, one cook, one kitchen assistant, two administrative staff and a maintenance person. We also spoke with the nominated individual, chief operations officer, the general manager, the regional manager, the clinical development nurse, the manager and deputy manager.

We looked at records including care plans, risk assessments, food and fluid charts, repositioning charts and medicines administration records for seventeen people who used the service. We also looked at nine staff recruitment records, training records and training matrix, rotas and other documentation related to the running of the service. We observed lunchtime in each area of the home and medicines administration.

During and following the inspection we contacted ERYC safeguarding and quality monitoring teams for feedback and to update them about our findings where we had concerns for people's safety. We highlighted concerns to the Health and Safety Executive (HSE). We spoke with two health professionals that visited the service regularly to obtain their feedback about the service.

Inadequate

Is the service safe?

Our findings

At the last inspection in September 2017 we had identified that people were not safe because staff had not followed correct procedures to report incidents. Risks to people's health and well-being were identified but plans to mitigate risks had not always been followed by staff and there were insufficient staff numbers to meet people's needs effectively. Medicines were not managed safely across the service.

This had resulted in breaches of Regulations 12 Safe care and treatment; 13 Safeguarding people from abuse and improper treatment and 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (HSCA 2008 (RA) 2014).

During this inspection we found that the provider had taken action and had shown some improvements. We found these improvements were insufficient to meet the requirements of Regulation 12, 13 and 18. This meant the service had not met the requirements of these regulations and there were continued breaches of Regulations 12, 13 and 18 (HSCA 2008 (RA) 2014).

Records showed that staff had raised several safeguarding allegations of potential abuse or neglect to the management team. However, none of these had been referred to the local safeguarding authority for investigation. This meant people were at risk of on-going harm. We made three safeguarding referrals and discussed a fourth concern which related to allegations of neglect and unsafe practices around health and safety. The local safeguarding authority is investigating these concerns and we will monitor the outcome of these investigations.

We found staff were knowledgeable about signs and types of abuse and how to report them, but despite this the four concerns had not been reported to external agencies. Staff had received training and although they had awareness of their responsibilities they trusted that management would deal with the referrals appropriately. In addition, they felt unable to raise their concerns anonymously to safeguarding as they felt such detailed information could be traced back to them. They feared this would result in repercussions and in turn they would be unable to protect those most vulnerable.

The relatives meeting dated 10th January 2018 and chaired by the general manager confirmed that staff were not trained to use restraint, only diversion technique training. We observed staff used restraint for one person even though they expressed non-verbally that they did not want this to be done. In this case untrained staff had used restraint against the person's wishes and this should not have happened. This person had discharge coming from their eyes, a senior member of staff asked an agency care worker for assistance. The agency care worker used a restrictive hold of the person's hands whilst the senior member of staff wiped the person's eyes. The person had not wanted their eyes wiping, when the person expressed a wish for staff to stop they did not respect their wishes. The person asked the staff to leave them alone after the use of restraint.

In addition, one member of staff said "We have a bath list and one person was forced to have a bath against their will which distressed them." We have sent information to the safeguarding team so they can investigate

and we will monitor the outcome.

This practice is not in line with Barchester's policies and procedures. Since the inspection process the provider has reinforced the distress reaction training to all staff so they have a clear understanding of what restraint is and that other least restrictive options that are available to them should be explored.

This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

We observed people were not provided with adequate supervision from staff when the environment posed a risk to them. For example, in the lounge there were two radiators which were uncovered and hot to touch. In addition to this there was an excessive amount of furniture in the same lounge area. This made it difficult for people to safely walk around the area and we observed people squeezing in between furniture increasing the risk of falling. This was of particular concern for people who did not have the capacity to recognise these risks. We discussed these concerns with the manager who confirmed that they would look into covers to ensure the risks posed by the radiators was minimised. In addition they had ensured that the furniture was removed later the same day.

Accidents and incidents were recorded in a centralised folder. However, potential risks had not always been identified and adequate actions taken. For example, one of the incident reports given to us by the deputy manager had not been fully completed to include actions taken by management to mitigate any risks. The report advised, "Workmen had taken the padlock off the door to the lounge." This area was being refurbished and should have been adequately secured so that people living at the service and any visitors could not gain access. Although the door was secured after the initial incident, the same person had gained access on a second occasion. The first incident report advised, "Found [Name] sitting on the floor in the lounge with paint on the floor around them and on their hands" and the second, "Lounge contains paint cans, power tools and sharps. [Name of person] had come out voluntarily." At the time of this incident workmen were using floor adhesive some of which was extremely toxic. None of the incident reports detailed checks made to ascertain the type of liquid spillage. The action of the provider failed to keep the person from the risk which was neglectful.

We had requested records of all accident and incidents, yet these incident reports were not given to us. Following the inspection we requested the completed incident reports which the manager forwarded to us. At the time of the incidents there was no record of any actions taken to mitigate further risks to this person or others. We informed the provider that we had made a report of our concerns to the Health and Safety Executive (HSE) who are responsible for regulating health and safety in care homes where works are being carried out. The provider also requested that their health and safety director complete checks at the home. Following the HSE inspection they confirmed that records were in place to mitigate any future risks.

Whilst some people had risk assessments in place these were inconsistent. Some contained detailed information on how to best support people to mitigate risks but others did not have information about specific health conditions or guidance on how staff should support them. For example, specific risks, such as those relating to Percutaneous Endoscopic Gastrostomy ((PEG) - PEG is a system used where people are having difficulty swallowing foods and fluids) had not been included in risk assessments. One person, who was being fed via a PEG tube, had guidance detailing the feeding regime, positioning, water flushes, fluid intake and output and weight monitoring. However, there was no guidance on the care of the PEG tube, routine skin care and guidance on when to seek urgent help.

We found care records were inconsistent in providing guidance to staff on specific health conditions and

how best to support people. One person had a risk assessment in place for thickener being stored in their bedroom to enable them to add the thickener to their own drinks, however there was no assessment of the person's competency to undertake this task. This meant that care records did not always reflect people's needs and how risks to them could be managed.

Medicines were not always safely managed. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely and checked regularly in three of the four areas of the home; one area did not record checks in line with the provider's policy. For medicines with variable doses an additional recording sheet had not been used consistently across all areas of the home to assist staff with recording doses administered. This meant that not all records showed the quantities administered and timing between administrations were not always clear to ensure correct spacing of medicines. For one person we found medicines were not administered in line with the prescribing instructions. Pain relief medicine had been administered at intervals closer than those prescribed increasing the risk of adverse effects from these medicines. As and when required medicines had protocols in place to guide staff on how to administer but records were not always made to detail the outcomes of these administrations. This made it difficult for staff to know the effectiveness of medicines and seek medical advice if additional administrations were needed. This increased the risk of medicine errors as records were inconsistent and did not identify errors in medicine administration.

One person told us, "Last night the nurse didn't turn up and I didn't get my tablets until quite late [11 – 11.30pm]. They [staff] apologised but everything was aching, my arms and legs" and on another occasion the same person advised us that they had used their buzzer during the night for pain relief – but that no staff had attended to them.

One person had been prescribed a toxic medicine which was being crushed – we saw that following the initial inspection day staff had sought advice from the pharmacist who confirmed that this medicine was not to be crushed. We sought further advice from the pharmacist who confirmed crushing this tablet would affect the dosage and absorption of the medicine. Since our inspection the manager had made a referral for this medicine to be reviewed and a risk assessment has been put in place.

Topical medicines were not always stored securely or administered as prescribed. Records were unclear and we could not be certain whether several people had received them as prescribed. One person had been prescribed cream twice daily – we checked records over a 5 day period, it had been recorded as applied 3 times a day for 4 days and on 1 day four times.

Infection control policies and procedures were in place. The crushers used for toxic medicines were not being cleaned after use increasing the risk of cross contamination. Wheelchairs and pressure relieving cushions were dirty and stained. There were no audits for cleaning pressure relieving cushions and checking records were not up to date for suction equipment, all sharps containers remained unlabelled and temporary closure mechanisms to reduce the risk of spillages not in use on any of the containers.

This was a continued breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Staffing levels were observed to be of a consistent level during our inspection. However, the arrangements in place for the deployment of staff across the home did not always take into account people's dependency levels so that staff could meet their needs. Whilst we saw some staff tended to people in a timely way allowing them to take things at their own pace, this was not always consistent across the service. For example, we observed staff struggling to assist people to eat and drink and people told us they had to wait

for personal cares during busy periods of the day in some areas of the home. Records confirmed eight people in one area required assistance to eat and drink and six of those were assessed as being at high risk of choking. During lunchtime we observed one member of staff serving meals, a second taking meals to people's rooms on trays, leaving a third member of staff to assist with feeding and observe those at risk of choking. This was not isolated to one area of the home.

One person living at the service told us, "You have to make allowances if they [staff] are busy." A second person said, "I feel safe" and a third advised, "Agency are not always up to the job."

Seven staff told us that the manager or deputy manager were responsible for completing the allocation of staff to each area in the home. However, four staff told us that the administration person had completed them for the last two week period. We asked to observe the manager completing staff allocation and rotas for the home. This did not take into account staff deployment during busy periods or the dependency levels of those that required full assistance to eat and drink.

Following the inspection process the provider has advised that staffing levels and deployment are based on the dependency levels of residents on each unit. Resident's needs are reviewed on a monthly basis or earlier should a significant change occur. This information is inputted into the dependency tool and staffing is recommended according to individual needs and dependencies on each unit. Rotas are completed by the unit managers to take into account the experience of care staff and nurses to ensure a good skill mix is always available. Where there are shortfalls and agency staff are required, the deputy manager requests this from a preferred agency supplier and in the majority of cases the same agency staff are allocated to ensure continuity of care provision.

Staff across three areas of the home told us they had raised issues with management that they were sometimes struggling to meet people's needs. They said they had been told that staffing would not be reviewed. They told us that rota's were regularly planned without taking into account staff skill mix and experience. One member of staff told us, "If we have regular staff we can just manage to meet people's care needs. It's when we have new agency workers who are unsure of people's needs and no additional staff allocated to support with that." A second member of staff said, "I don't feel we can deliver person centred care. I love my job and we all try our best, but I feel the support is not there to allow me to do my job to the standards I would expect for people."

In relation to issues raised around answering of call bells, we asked the regional and home manager if there were any monitoring systems in place to ensure call bells were answered in a timely way. They told us no systems were in place and they were unable to provide us with any data to show how often or when call bells had been used.

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

One member of staff told us that a senior person had completed a full shift, gone home for a short period and then returned to complete another shift. They advised this had been agreed with management and meant they had almost worked a twenty four hour period. Following the inspection the provider advised that this was a one-off emergency situation, as the booked agency nurse did not arrive for duty and all other agencies were unable to help. However, the provider employed 100 people at the time of this inspection and so this practice highlighted ineffective contingency plans being in place to ensure appropriate processes were in place to cover staffing issues during emergency situations and this has been reflected in the well led domain of this report.

In addition, another member of staff had been asked by management to cover on call through the night. The member of staff had asked if someone else could cover as they were tired and just worked six consecutive shifts. We were told that management had not asked other seniors to cover, yet there were other people that could have covered the on call. The NHS Choices website advises; "An occasional night without sleep makes you feel tired and irritable the next day, but it won't harm your health. After several sleepless nights, the mental effects become more serious. Your brain will fog, making it difficult to concentrate and make decisions. You'll start to feel down, and may fall asleep during the day. Your risk of injury and accidents at home, work and on the road also increases." We asked the provider to investigate the first concern to ensure it is not accepted or regular practice.

The provider had a whistleblowing policy and procedure in place which detailed alternative avenues for staff to raise their concerns anonymously. This included the whistle blowing helpline which the provider advised was operated by an independent third party and any investigations are supervised by Barchester's Human Resources Department. In addition, several managers were available to approach at different times within the home. The provider told us that they welcomed any constructive feedback from staff. Despite these measures being in place 11 of the 34 staff we spoke with out of the 83 employed told us they felt unable to utilise the whistle blowing procedures.

Several staff told us that a senior manager was "aggressive" towards them; we had other staff that had described a bullying culture within the service. One member of staff we spoke with was due to leave and they advised, "I love my job, but I feel they (management) are pushing me out." We looked at this person's last supervision where they had advised they "felt unappreciated." There had been no other recorded issues around the conduct of this member of staff. A second member of staff felt vulnerable talking to us, as they had no confidence that management were addressing their concerns appropriately. Several staff did not want to be seen talking with us and so we offered to speak over the telephone following the inspection which they accepted. These staff felt if they were seen talking to us they would be dismissed by the management. One member of staff advised, "I am not confident confidentiality would be maintained by management." This was supported by several other staff that felt the same. Following discussions with the provider we were given assurances that they were working to address these areas and ensure that staff felt comfortable raising their concerns in the future. The provider had also recognised the need for additional management training to support managers in developing their skills and expertise to support their staff.

Recruitment records showed that references and disclosure and barring checks (DBS) were completed prior to staff being employed by the service. DBS checks were in place to check people's background to ensure they were of suitable character to work in a care environment. The provider had focused on recruiting permanent staff to the service. The manager told us this had decreased the need for use of agency staff. Records showed that usage of agency staff had decreased since our last inspection. The manager told us that if agency were needed they asked for regular staff that had previously worked at the service. The manager was realistic in that this could not always be accommodated but they tried to ensure where possible the agency supported them to maintain consistency of carers for people.

Improvements had been made in relation to fire safety. Additional ski pads had been purchased to assist with safe evacuation of people with poor mobility living upstairs. Agency staff had been included in fire drills and the majority of staff had completed scenario based fire training. Records showed regular maintenance checks had been completed and certificates such as those for electrical safety and lifting equipment were up to date.

Emergency plans were in place and the personal emergency evacuation procedures (PEEP's) contained sufficient information for staff and emergency services to support people to leave the premises in the event

of an emergency.

Policies were in place to protect people from discrimination..

Requires Improvement

Is the service effective?

Our findings

At our last inspection in September 2017 we had found that staff training was not up to date and staff practice demonstrated a lack of knowledge and understanding of people's needs. Staff supervisions had been carried out and used for training rather than the support and development of staff. People's nutritional and hydration needs were not always met and staff did not follow good practice guidelines when supporting people to eat and drink. Improvements were also required to ensure a dementia friendly environment to meet the needs of those living with dementia.

This had resulted in breaches of Regulation 11 Need for consent; 14 Meeting nutritional and hydration requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the provider had taken actions to improve practices within the service. We found these improvements were sufficient to meet the requirements of Regulation 14, but insufficient to meet the requirements of Regulation 11. This meant the service had not met the requirements of this regulation and there was a continued breach of Regulation 11 (HSCA 2008 (RA) 2014).

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw associated conditions within the DoLS were being met.

Records showed people who did not have capacity to make decisions, had not always had mental capacity assessments and best interest decisions completed for their care and treatment in line with the MCA. For one person we saw a mental capacity assessment for bed rails; however a record of a best interest decision showed involvement from staff only with no involvement by family or professionals. We saw some best interest decisions for taking photographs that did not advise the names of those people consulted with; they only recorded "Others consulted." One person's family member had signed a consent form for photographs to be taken. Staff told us the family member had no authorisation in place to be able to make decisions on behalf of the person. Therefore, a best interest decision should have taken place.

We observed staff used restraint for one person that had capacity, against their will. In addition the staff had not lawfully obtained the persons consent prior to carrying out this practice. This meant that people were being placed at risk of harm as staff were using restraint with no formal training being in place. People's rights to make particular decisions had not been upheld and their freedom to make decisions had not been maximised, as in some cases unnecessary restrictions had been placed on them.

There was a policy and procedure on the MCA and DoLS designed to protect people and staff had received training. The manager had applied to renew DoLS authorisations prior to their expiry dates. However, some staff knowledge and practices around MCA was poor. For example, one senior member of staff had poor knowledge of when a mental capacity assessment or best interest decision was required. Two people had been moved into a different room due to refurbishments taking place and a mental capacity assessment, best interest decision and consultation with their family or representative had not been considered or completed prior to this happening.

Records showed that Do Not Attempt Cardio Pulmonary Resuscitation consent forms (DNACPR) were not always reviewed regularly to ensure they were kept current and in line with peoples wishes. For example, one person's DNACPR detailed their home address as the form had been initiated in the hospital setting in June 2016. The Resuscitation Council recommends that a decision about CPR is reviewed whenever a person moves from one setting to another, to ensure that the decision is still the right one for the person. The Unit Manager told us that they would contact the GP to arrange for a review. Another person's DNACPR advised it had been discussed with the daughter in December 2017 and was valid until end of life. However, more recently the care plan stated in the event of sudden collapse the person would want CPR. We raised this with the provider and they have confirmed that this has been reviewed and updated to respect the person's wishes.

This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

Staff supported people to ensure they received adequate nutrition and hydration. We observed food and fluids being offered to people regularly, fluids were available in bedrooms and communal areas. 'Hostesses' had been introduced to support staff to ensure people received regular drinks and snacks throughout the day. Some of these staff had previously worked in a caring role and were extremely knowledgeable around people's needs and how to best support them. One member of care staff said, "Hostesses have made a huge impact, we need them – they do a brilliant job." Food and fluid charts were in place for those highlighted as being at risk of malnutrition or dehydration. However, one person had been identified as losing weight over a six month period and their food and fluid charts recommended high calorie mousse or fortified drinks to be encouraged regularly. The care plan advised that additional options such as jelly, ice cream, soups and milkshakes were to be offered to increase food and fluid intake. The fluid charts did not show that regular high calorie drinks had been offered to this person – over a period of two days none were recorded as offered. Their food chart showed over a period of 4 days only 2 slices of cake had been eaten. The providers quality improvement review dated 22 March 2018 confirmed there had been no GP or dietician referral for a person that had lost 8.1kg of weight over a six month period.

We spoke with staff and discussed whether they had offered sweeter options to encourage food intake as records showed the person appeared to enjoy these. The staff told us they had not considered this and started to offer alternatives which the person had then eaten. We rechecked food and fluid charts on a later date which showed an improvement in their intake over a five day period. This appeared to be an isolated incident.

Fluid charts were inconsistent in recording of information to guide staff on individual's recommended daily intake. We discussed these issues with the regional manager during feedback and were advised this would be an area of focus. Despite this we did observe improvements had been made in this area since our last inspection and measures were in place to ensure food and fluids were encouraged by staff at regular intervals during the day and night. This practice was observed during the inspection process and although some relatives had raised specific issues the management were keen to ensure people's nutritional needs

were met. We noted this as a recording issue in the well led section of this report as there was minimum impact on the people living at the service.

People's needs were assessed prior to moving into the home to ensure staff could meet them and equipment put in place to ensure peoples safety and comfort. When support needs had been identified, a care plan was put in place to guide staff. However, we found some assessments contradictory and they did not include care plans for all conditions identified at pre-assessment stages. For example, one person's pre-admission assessment identified three specific conditions, but no care plans were in place. It also advised the person had a condition which meant there was an absence of an ability to form speech, it also stated, "Shouts out repetitively." The communication care plan had been reviewed February 2018 and stated the person was able to speak.

Assessments were in place to identify those people at risk of developing pressure ulcers and preventative measures such as pressure relieving mattresses in place. Detailed care plans were in place to inform staff of interventions required to ensure healthy skin. Systems also ensured those residents cared for in bed were repositioned at regular intervals to maintain skin integrity. Wound treatment plans were clear and detailed including a description of the wound, progress made and observations needed in the event of deterioration. Staff had worked alongside the advanced nurse practitioner who had given specialist support in relation to care. Plans were clear for staff to follow in the event of anyone falling. People's continence needs had been assessed and care plans developed.

Mobility needs were identified and specific plans for supporting people with their mobility needs and transfers were in place and regularly reviewed. However, for one person who had contractures of both legs there was limited detail as to how the person's legs were to be supported. This meant that the person's contractures could worsen without correct support. Care plans had been reviewed and updated monthly.

Recognised tools such as the Waterlow pressure ulcer risk assessment and Malnutrition Universal Screening Tool (MUST) were used, which helped identify the level of risk. The Waterlow scale is used to assess people's risk of developing pressure sores. Assessments were regularly reviewed and updated to ensure they reflected people's current level of risk.

Staff knowledge was good in relation to people's likes, dislikes and preferences. We observed some good interactions between staff and residents when managing difficult situations. For example, one person was shouting out in a communal area and staff attended to them immediately to diffuse the persons distress. Staff asked what the person would like and they responded by saying they were unsure. Staff gave them some options and they chose to walk back to their bedroom with the support of staff gently encouraging them to do this independently.

The adaptation and design of the premises had been improved to include; spa baths for a more sensory bathing experience, outside areas which were accessible and consideration had been given to change access to areas to minimise disruption to people. Some relatives had mentioned that, "Hot drinks had been removed from the upstairs lounge/dining area, so they were unable to make their own hot refreshments when visiting relatives. They advised that if they wanted a hot drink with their relative who had no mobility to leave their room, it meant they had to walk from downstairs to upstairs with a hot drink. Following the inspection the provider advised that each area of the home had its own satellite kitchen where drinks could be prepared.

We observed people moving between different areas of the home during group activity sessions or meal times with and without the support of staff. One person was unable to orientate themselves and was

confused as to where they were going. There was a lack of signage to enable people to orientate themselves independently around the home. The provider assured us that dementia friendly signage would be improved during the final refurbishment plans to support people's independence.

Permanent staff told us they had completed a four day induction prior to commencing work at the service which included; safeguarding, basic dementia and moving and handling training. Staff were introduced to people they would be supporting and given time to read the home's policies and procedures. The manager told us senior staff supported new recruits through a period of mentoring to build their confidence until they were competent in their role. Annual refreshers were scheduled for courses such as; safeguarding adults from abuse, fire, health and safety, moving and handling and the use of slings and equipment. Agency staff received training through their agency and then the provider induction included; an introduction to the home, emergency procedures, health and safety, and how to complete documentation. The provider had profiles of each agency worker detailing the training they had completed.

One member of staff told us, "We have received additional training like 'React to red'- which was delivered by a tissue viability nurse. It was really good." This training supported staff in preventing and managing pressure sores. One member of staff advised, "Some training is not sufficient and doesn't give staff enough detail and practical experience to carry out their role." When asked which courses they felt were not detailed enough they told us the distress reaction training has no practical element and the moving and handling for those new to the caring role was insufficient. We did observe some inappropriate moving and handling techniques which we discussed with the provider. However, some new staff did demonstrate good knowledge of moving and handling techniques and we observed some good practices throughout the home.

The provider had introduced scenario based fire training as recommended by the fire officer during their last fire inspection. In addition, fire drills included all agency staff. The manager told us that all staff including agency were expected to attend a minimum of two fire drills annually – the health and safety policy stated four annually. The manager told us that agency staff always worked with a senior or experienced member of the team for up to two weeks before working alone in the service. However, during one day of the inspection two agency staff were working together, one told us it was their first day at the service. Both had poor knowledge of fire evacuation in the event of an emergency and the new agency person told us they had not completed any fire training at the service demonstrating that the training for agency staff was not always robust.

Supervision records were inconsistent; some were detailed and addressed concerns and staff development. However, some were very brief and requested additional training such as first aid and dementia, but these had not been actioned or followed up by their manager. The manager told us that supervisions were held with staff every three months; however two staff files had six months or more in between supervisions. The provider had introduced observational and skill supervisions in between regular supervisions. The skills supervisions concentrated on specific areas such as the accurate completion and management of the medicines administration records. These were sessions where information was given to people around how certain tasks should be completed. The observational supervisions observed areas such as fire evacuation practice to ensure these were completed in line with the provider's policies and procedures. These provided a level of competency and educational content to develop staff knowledge and skills. Not all staff that had been employed over 12 months had appraisals in place, the manager advised they were in the process of updating these. The latest staff meeting minutes from March 2018 confirmed, "Appraisals at 55% - needs to be a focus."

Requires Improvement

Is the service caring?

Our findings

At our last inspection in September 2017 we found variations in the care provided to those people living with dementia. People's dignity had not been supported through the care they received and people's personal hygiene and appearance had not been managed well by staff. We saw some examples of staff having a lack of awareness and being uncaring.

This had resulted in a breach of Regulation 10 Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the provider had taken actions to improve practices within the service. We found these improvements were not sufficient to meet the requirements of Regulation 10. This meant the service had not met the requirements of this regulation and there was a continued breach of Regulation 10 (HSCA 2008 (RA) 2014).

Records confirmed the level of support people required to maintain personal hygiene, together with access to the dentist, optician and podiatrist. We looked at one person's care plan which stated that the person liked to be well dressed and would like to wear pearls for special occasions. Another person care plan noted that the person could be "physically aggressive at times during personal care" and gave guidance to staff to allow the person to calm down and return after a few minutes. However, there was no further specific guidance for staff so that they managed situations in a consistent and positive way to protect the person's dignity and rights.

Refurbishments were underway during the inspection and many people, relatives and staff commented on the noise levels in some areas of the home. Some people had been moved to protect them from any noise disturbances. However, one person had been moved to a room that had previously been occupied by another person whose belongings were still in the room. This meant that although people had been moved due to noise disturbances the provider had failed to ensure their belongings were moved with them so that people's personal belongings were respected and people had their own familiar items around them.

We observed one person walking in and out of people's rooms with no staff present to supervise or intervene. In some areas apart from when tasks were being completed there was very little meaningful interaction seen between staff and people who used the service. One relative told us, "People do walk into rooms and take things but they usually turn up again."

One relative mentioned that the required a private space to talk with formal visitors coming into the home. They had discussed this issue with the manager as their relative's bedroom was inappropriate to use and they felt no other suitable rooms were available. The manager offered them their office as a solution, which the person told us they would ask to use for these specific appointments. This did highlight that people needed to know areas were available to them if they needed a quiet and private place to talk with visitors.

This was a continued breach of Regulation 10 of the Health and Social care Act 2008 (Regulated Activities)

Regulations 2014. Dignity and respect.

One member of staff told us, "We are all working better as a team to support one another." We observed kind and compassionate support being provided whilst staff promoted people's privacy and dignity. One person sitting in a lounge with their neck bent to one side was asked by staff if they would like a pillow to make them more comfortable. Another person had spilt some food and fluid down their clothes protector and staff were quick to ensure this was removed so that the person maintained their cleanliness. We observed staff welcomed relatives and visitors into the service and quietly talked to them when they asked any questions.

In some areas the activities board did not always reflect the activities being carried out that day. We asked staff in different areas of the home where activities were being held and they were often confused as to where group activities were located. An orientation clock used to assist those people living with dementia had the incorrect date and year displayed.

The provider told us that they improved communications by sending minutes of relatives meetings to people keeping them informed of current changes. Meetings continued every morning with seniors from each area of the home attending to discuss clinical aspects of people's care including any specialist referrals to other health professionals and appointments scheduled. This also gave staff the opportunity to seek guidance and advice or raise concerns to the management team. We discussed the above inconsistencies with the provider and they acknowledged that further improvements needed to be made. They told us they would continue their efforts to improve the experience for people living at the service, their relatives and staff.

People we spoke with confirmed they had been involved with the planning of their relatives care. Care plans included where appropriate, records of communications completed with people's relatives although some reviews we saw were very brief around the input relatives had contributed and were more a statement that they had been present and were happy with the content. The provider's quality improvement plan dated 22 March 2018 had identified involvement of people and their relatives were "not consistent and undertaken six monthly". The provider already had plans to improve these practices.

We spoke to people using the service and generally they felt they were well cared for. One person described staff as, "Excellent. They help me with my food and dressing" and a second person told us, "The care workers and nurse are absolutely brilliant. I have no complaints at all." A third person said, "The carers are alright." Relatives told us that staff were kind. One relative said, "The permanent staff are brilliant." A second relative told us, "The female staff are good with [Name], they reassure when anxious or crying. They are good to [Name]." A third relative advised us that practices were inconsistent and gave an example of one able person receiving a sensory bathing experience in the newly refurbished spa bathroom – but that this was not extended to their relative who was less able. They had not been given a choice and taken to one of the standard bathrooms.

Staff had mixed understanding and knowledge about the diverse needs of people they were supporting. In care plans the guidance for staff to follow was not always clear or fully documented. For example, for one person care planning was unclear as to whether staff should encourage or discourage certain food types. The cook understood the specific needs of this person and ensured certain foods were replaced with others to meet their beliefs. The majority of staff we spoke with were unaware of the additional efforts the cook had taken which were above and beyond to meet this persons individual needs. The manager told us they would revise this person's care plan so that guidance was clear for all staff to follow. Some people told us they attended local church services independently and another person had someone visit them from the

Catholic Church.

Staff knew the importance of offering people choices. A member of staff told us that certain people preferred females to attend to their personal cares and that their wishes had been respected. One member of staff said, "Some people choose to stay in their rooms and others move between different areas of the home. People eat in other areas of the home and sit with their friends."

Staff had a good awareness of the importance of maintaining people's independence. For example, one person wanted to walk from the dining area to their room without using their wheelchair. Three staff worked with this individual to achieve their goal and showed patience alongside their commitment to improving people's quality of life taking into account their preferences.

People told us and our observations confirmed visitors were welcome to visit without any time restrictions. One relative told us, "I can visit at any time and staff are always welcome me" and a second relative said, "The staff are very good, even the domestics spend time talking to [Name]." This relative also commented on how staff cared for her needs too, "Staff give me a hug and always check I'm ok."

Personal documents were held in locked offices and cabinets within each area of the home. However, during one day of our inspection a person entered the administrator's office which was unattended and unlocked. We intervened and asked the person whether they were visiting or worked in the service – they were working for the service but not in a caring capacity within the home. In the office were documents relating to staff supervisions and some records relating to incidents and accidents – these documents were on the office desk and visible to any person entering.

Some people had advocates in place and the service provided information on local advocacy services in the area should people need to access them. An advocate is an independent person that has permission to speak on behalf of a person that may be unable to express their views. This ensures that people have a voice and that their best interests are upheld.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in September 2017 we had found that care plans did not always reflect the care people received and did not always reflect their preferences. Activities were not meaningful or provided each day. This had resulted in a breach of Regulation 9; Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the provider had taken actions to improve practices within the service. We found these improvements were not sufficient to meet the requirements of Regulation 9. This meant the service had not met the requirements of this regulation and there was a continued breach of Regulation 9 (HSCA 2008 (RA) 2014).

Care plans we looked at contained some person centred information on people's support needs. However, others were brief and more task based, with less specific information to guide staff. For example, one person's care plan identified that they had panic attacks, but there was no guidance for staff about what might trigger an attack or the best way to support them. Another person with sight difficulties had been diagnosed with a specific condition, there was no care plan or risk assessment in place for the diagnosed condition so that staff were aware of how it may affect the person and how best to support them. A third person who had contractures of both legs there was limited detail as to how the person's legs were to be supported. This meant that the person's contractures could worsen without correct support.

We saw a range of care plans to meet a person's daily needs, together with additional care plans. For example for nutritional support we saw a 'nutrition and hydration care plan', a 'poor diet intake/low weight/low BMI care plan', together with a 'choking care plan.' We reviewed several care plans and saw that information was often duplicated. Recording of information in the majority of care plans we reviewed was inconsistent including some risk assessments that were not aligned with the appropriate care plans. For example, one care plan for a person's wound was not up to date; it identified an un-gradable pressure sore in the manual handling assessment. However, when we spoke to the nurse they told us the care plan was referring to a previous wound and that the person only had dressings for protection.

Limited communication care plans were in place. We saw basic information for staff to follow in relation to how they engaged with people. For example, one person's stated that they could answer a simple yes or no question. For another person the care plan stated that they could speak clearly, however they could not reliably communicate their needs and indicated that these must be anticipated. Some people were unable to use their call bells and in some care plans there was no guidance on how staff should manage those difficulties to support people.

When support needs had been identified, a care plan was put in place to guide staff. However, we found some assessments were contradictory and they did not include care plans for all conditions identified at pre-assessment stages. For example, one person's pre-admission assessment identified three specific conditions, but no care plans were in place. It also advised the person had a condition which meant there was an absence of an ability to form speech, it also stated, "Shouts out repetitively." The communication

care plan had been reviewed February 2018 and stated the person was able to speak. This shows that the provider has not developed all care plans sufficiently to support person centred care.

Some staff raised concerns around regularity of baths and showers for those people who were less able or that had more complex behaviours to manage. One member of staff advised, "We don't have time to interact with people or to re-offer a bath or shower to a person that may have declined one earlier. People's nails are not trimmed as often as they should be."

We spoke to staff and asked them about accessible information standards (AIS), one member of staff told us they did not understand what AIS was and they had not received training on the subject. AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss were given information in a way they could understand. We saw little information to show that the provider had taken the standards into account to support people's understanding.

Relatives we spoke with felt confident that people were receiving appropriate input from health professionals. Some records showed referrals had been made by staff when appropriate for additional support or advice. However, one person's care plan stated, "Vision and eye health checked yearly" and their records showed they had last seen their optician in August 2016. Another person's care plan confirmed a person was on a pureed diet and thickened fluids as prescribed by the GP, but no referral had been made to the Speech and Language Therapists (SALT) to ensure they were monitored and supported in the right way to meet their specific needs.

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

The provider had enlisted the support of their own dementia specialist to ensure meaningful and stimulating activities were developed for people. However, we received mixed feedback from staff, relatives and people living at the service. We observed some planned group activities during the days of inspection. These included a singer and some chair exercises followed by a quiz. Staff encouraged people to participate to the best of their abilities during group activity sessions which were well attended. The activities team had been increased since our last inspection to include an additional activities assistant and a bank person to support when needed. One person living at the service told us, "We had a singer come in twice last week which we all enjoyed." The home was also ensuring outside areas could be utilised weather permitting and we heard staff offer one gentleman support to sit outside and discussed doing some gardening in the summer to which he responded positively.

One member of staff said, "Activities have improved since the last inspection and Christmas was really good we had lots going on. Over the last couple of months it seems to have gone downhill." Another member of staff told us, "We are expected to provide one to one activities for people, but we just about manage to complete basic care needs and rarely get time to spend with people on a one to one basis." A relative told us, "I have not seen [Name] attending activities and although I asked that they attend an event outside the home, I'm unsure as to whether they did as I have received no feedback from staff."

We spoke with health professionals that visited the service, they voiced concerns that they had difficulties ensuring one person received stimulating activities and interactions. They told us that the lack of stimulating interactions and activities had been a trigger in the past which escalated this person's behaviour. They had enlisted the support of the Occupational Therapists who had worked alongside staff and provided additional training to support them in managing effective interactions with people. Despite the additional support they felt the staff had given up on this person and rarely saw any meaningful

stimulation during visits. This person was due to move from the home as the provider had indicated they could no longer meet their needs.

We observed some positive and meaningful interactions between staff and people living at the service. For example, a member of staff had found that a person responded to a particular type of music and so asked the activities co-ordinator to include this in their activity plans. Another person had an empathy doll and we saw others using teddy bears to hold which appeared to comfort them. However, in other areas nothing was in place to stimulate people. One person walked continuously up and down the corridor. We interacted with them and they used different facial expressions and verbal sounds to communicate with us. They appeared to enjoy singing and smiled during interactions. When we reviewed their care plan it listed all their likes and dislikes, previous occupations, hobbies and information from family members around how best to communicate with them. Despite the detailed information staff had not utilised this to provide person centred activities or meaningful interactions with this individual.

The provider had purchased a mini bus to ensure outings into the community improved for people living at the service. We spoke with a member of staff that supported with this and they told us, "Two to three residents attend most trips once a week as two staff usually have to escort each resident so this limits how many can attend." However, once a month they tried to organise bigger events so more people could attend such as going to a local garden centre for coffee and cakes. Elvington Air Museum had been a recent trip organised by staff. One relative advised, "It would be nice for [Name] to be taken out once a week even if it's just into the local village." One person living at the service said, "We can't go out you see, unless relatives come."

Records of one to one activities with people had no times recorded and notes indicated they were very short periods of time. For example, "Had a chat." When we asked two staff about recording times they advised the dementia specialist had told them not to record times as people living at the service were unaware of the time. In some areas of the home senior staff told us that people were not good at recording their interactions, such as hand massaging and painting people's nails. During the inspection we observed very little interactions for those people isolated in their bedrooms. We requested that all one to one activities and interactions record times.

People knew how to raise concerns or complaints. One relative told us, "I speak to the staff or the manager at the home." We reviewed records of complaints and found that some were of a safeguarding nature – the manager had documented discussions with the safeguarding team on the occasions when they had not met the threshold to send an alert to them. Another complaint was recorded on a review, outcome and lessons learnt form. Guidance had been recorded for staff to ensure they were aware of the current updates and to report any further incidents. This ensured that the best interests of the person living at the service were maintained.

One member of staff told us the provider had introduced an 'About Me' document summarising people's needs, likes, dislikes and preferences. They told us, "Each person has a named nurse and keyworker." Another member of staff advised, "There are laminated cards in people's bedrooms so that staff and in particular agency staff have a guide to follow about people's specific needs." This supported staff to ensure people's needs were met.

Care plans were in place for people, with terminal and life limiting illnesses which meant information was available to inform staff of the person's final wishes to ensure these were respected. One resident we spoke with told us of their recent loss, "The staff couldn't have been better, they were excellent that night." They told us how the staff had supported them and stayed with them all night so they were not alone. Other

relatives had sent thank you cards to the service for the care and devotion of staff during their loved ones final days.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in September 2017 we had found that there was a lack of effective leadership, the provider had arranged management support to address this area. The quality assurance systems in place had not been effective in identifying risks to people's health and safety. Audits used by the service had failed to identify shortfalls in care and safety. Notifications had not always been made to CQC and the local authority regarding safeguarding matters.

This had resulted in a breach of Regulation 17; Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had put a voluntary embargo on admissions to the service which had been formalised by CQC and the local authority – at the time of our inspection this was still in place.

During this inspection we found that the provider had taken some actions to improve practices within the service. We found these improvements were not sufficient to meet the requirements of Regulation 17. This meant the service had not met the requirements of this regulation and there was a continued breach of Regulation 17 (HSCA 2008 (RA) 2014).

There was a manager employed at this service; they were also a qualified general nurse and had submitted an application to register with CQC which was in progress at the time of our inspection. The manager told us they had a period of acting up into the role since their start date on 2 January 2018, this had been supported by the regional and acting manager. The acting manager left Stamford Bridge Beaumont on 26th January 2018 and the current manager was in post from 27th January 2018. The manager continued to receive weekly support from the regional director, clinical development nurse and the acting manager during their three month induction into the service and told us they felt supported.

Records had been inconsistently completed and lacked vital information to guide staff in their judgements. During our inspection we saw that the majority of fluid charts were not totalled, recommended daily amounts for individuals were not recorded and handover sheets were not always aligned with food and fluid charts. One handover sheet stated a person was "low risk of choking" yet the fluid chart said, "At risk of choking." Diabetic information was on the food chart but not on the handover sheet. One food chart stated "fork mashable diet" but no details of this were on the handover sheet. Care plans and risk assessments were not always aligned and did not always reflect people's diagnosed medical conditions. This meant that the provider had failed to keep contemporaneous records and that vital information to guide staff was sometimes unclear and posed potential risks to people - the providers systems had failed to identify these concerns and address them.

Levels of dependency in some areas of the home had not been taken into account when the provider allocated staff in different areas of the service. This had an impact on the level of support people received such as having enough staff assist to eat and drink during mealtimes. The provider told us they would look to stagger mealtimes for people to ensure staff could manage this appropriately. In addition, staff experience and skill mix had not been taken into account when deploying staff to higher dependency areas

within the home. Senior staff told us, "There is a lack of ownership for allocation of staff. The administration person has completed rota allocations this week yet they do not know staff competencies - unit managers should have input as they know their staff." Another member of staff told us, "When I receive the allocation I always have to jiggle it around as it's not workable." This demonstrated a lack of management oversight.

Following the inspection the provider advised that the general or deputy manager completed daily allocation sheets, taking into account both employed and agency staff including their experience and knowledge of working within each area of the home. This supported the deployment and skill mix of staff across the home and could be altered to account for unforeseen events such as staff sickness at short notice. The general or deputy manager would approve any changes to the allocation sheet so that skill mix across the home and individual areas was taken into account.

Accidents and incidents were being recorded in a centralised folder. However, two incidents were not recorded in the incident folder and no actions to mitigate the risks had been completed by management until ten days after the initial incident had taken place. This had resulted in a similar incident taking place on a second occasion. We identified several areas of risk within the home that the provider had not identified in their own audits. Therefore, risks were not being adequately assessed or managed, leaving people at risk of harm.

Safeguarding issues we identified had not been highlighted through the providers monitoring systems. This meant they were not always effective.

Fire drill records were inconsistent; several did not include a date as to when they had been completed. This meant we could not rely on documentation to confirm that both permanent and agency care workers had attended the provider's recommendations for attendance of fire drills.

Some staff told us the communication had improved and that regular meetings supported them to carry out their role. However, several staff advised that communication was at times lacking between themselves and management. For example, staff told us they had raised concerns around appropriate staffing to meet people's needs. Staff told us that although they had been listened to; their concerns had not been acted upon by senior management. Other staff felt that when events were organised this was not communicated in a timely way so that staff could prepare or collate necessary items to deliver the activities specified.

We received inconsistent feedback from relatives in relation to the communications from the home. Some told us, "The relatives meetings are more regular. I speak to the manager, but as a family we are very hands on and visit often so we make sure we ask questions and staff always keep us updated." Others felt that this area would benefit from further attention and advised, "I emailed several items to be added to the meeting agenda, but this did not happen and so my concerns were not discussed." The manager told us they used a daily diary to capture issues which they then addressed formally and documented. However, some of these issues had not been formally recorded with actions taken. The provider stated that seven relatives meetings had been held since 25 September 2018, one of those in February 2018 had been cancelled due to extreme weather conditions taking into account people's safety.

Some staff felt unsupported and that they were unable to raise concerns with the management team due to breaches of staff confidentiality and a fear of repercussions. Staff felt there was a lack of ownership when problems were reported to senior managers. One staff member told us, "Staff are told by managers that it has been passed to someone else to deal with and never receive any feedback. It is better to receive valid feedback than nothing at all if management are unable for whatever reason to address things – instead staff are left in the dark." Two members of staff told us that they been asked by management to falsify records by

signing off charts that had no signatures from the last shift. A third member of staff told us they had refused to do this. We asked the provider to investigate some of the concerns raised by staff and provide us with feedback.

A number of quality assurance systems were in place which highlighted areas requiring improvements. However, these did not always contain sufficient detail and did not highlight some of the areas of concern found during this inspection. The provider told us that their governance framework consisted of visits such as; 9 visits per year by Regional Directors, two day visits 3 times a year by the Quality Improvement Specialist team, monthly audits by the General Manager and unannounced risk-based audits by their internal Regulation Team. Actions arising from these visits were recorded on a Central Action Plan for completion by the General Manager and signed off by the Regional Director. Progress was monitored and reviewed with the Senior Management and Executive Teams and any issues that were not addressed were escalated to them. The internal regulation team had completed audits to review the homes progress in relation to their CQC action plan in December 2017 and then a follow up visit in February 2018. The outcomes did confirm the provider was addressing concerns and making improvements across the service.

However, further improvements were needed to identify issues and ensure they were addressed effectively. For example, some site visits identified repetitive issues such as, name badges not being worn (over three site visits) and food and fluid charts not being completed or totalled (over several site visits). When improvements to food and fluid charts were noted the management had acknowledged the efforts of staff. However, audits lacked detail such as action by dates and did not support staff in a consistent way to action improvements such as offering additional training. During our inspection, charts had been completed differently in separate areas of the home and no support such as additional training/discussions were documented on audits.

The manager told us they completed a daily checks around the service each day – this was a tick list of areas within the home such as, minutes of meetings completed, check for odours, healthcare professionals visits scheduled, checks of food and fluid, topical records and positional change charts. However, no details were recorded as to which charts had been checked – the list just recorded a simple yes or no. On one list dated 12 February 2018 it had ticked that people, "looked isolated and bored" but no actions were noted. This checklist also advised, "Speak to residents and relatives" yet no details had been recorded. This meant that no senior managers could audit the checks and the same charts could have been audited more than once or the same people and relatives spoken to.

Monthly audits case tracked residents care and support, spoke with staff, residents and their relatives, but no details of these conversations or the names of these people were recorded. One audit identified that a person did not have their call bell in reach and they needed personal care, the actions taken were to brief staff in a stand-up meeting. There were no details of any future checks to ensure this was actioned. Medicines audits did detail people's initials for MAR charts that had been reviewed, but did not detail the area of the home that had been checked. This meant the audits were not effective in driving improvements across the service. There was potential for duplication and repetitive auditing of the same records.

We reviewed the business continuity plan which had been reviewed on 17 January 2018. This detailed important contacts in the event of any disruptions to the service. However, some of the service providers names had changed due to them merging with larger organisations and some of the contact numbers were out of date including those for out of hours. This meant that some areas lacked management oversight and reviews of documentation were not always thorough.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

2014 – Good Governance.

The manager was aware of the types of notifications they were required to send to the Care Quality Commission as part of their registration requirements. However, we had not been notified of allegations of abuse raised by staff at the service. This information has been referred to the local authority to investigate and we will monitor the outcomes. This indicated a lack of transparency on the part of the manager.

Policies and procedures were in place to guide to staff on topics such as; infection control, safeguarding adults and duty of candour. The provider's quality improvement plan dated 22 March 2018 had identified that duty of candour was not always followed by staff. The duty of candour was introduced to ensure providers of health and social care in all settings are open and honest with people and their relatives or representatives. When something has the potential to cause, harm or distress to a person the provider has a responsibility to apologise to the person or where appropriate the relative or representative chosen by that person. This creates a more open and inclusive culture of honesty and transparency. This was an area of focus for the provider and although previous supervisions had included discussions around this topic they felt further support was needed.

The manager had not fully addressed the alleged bullying culture of senior staff within the home. As a result the inspection team were not confident in the leadership of the service at the time of this inspection. The nominated individual assured us during feedback that any issues of conduct would be fully investigated and addressed. We are awaiting the report from their investigations and will monitor the outcomes from this.

Systems had been improved to monitor some areas relating to health, safety and welfare of people. Hourly observations were in place and repositioning charts which had been completed in line with the care plan recommendations. Resident of the day forms were completed – these took a sample of different people to audit each month and included reviews of tissue viability, care plans, risk assessments, accident/incidents of individuals and medicine charts. Reports were regularly reviewed by nurses in each area of the home, such as tissue viability reports to ensure wounds and skin tears were managed effectively and appropriate health professionals involved.

The service had been working in partnership with other organisations, such as the local authority and the clinical commissioning group and we received some positive feedback from their visits. Regular relatives meetings gave people chance to raise any concerns and discuss them with the manager. The provider told us they were improving their approach to ensure a more structured and organised meeting to encourage opportunities for relatives to discuss agenda items they may have submitted.

The registered provider's representatives responded to our request to carry out some internal investigations, some of which are on-going. Senior managers within the service took steps to make improvements following feedback given during and after the inspection and planned to update us with the outcomes of all their investigations when completed.

Improvements had been put in place in many areas of the service and although we have highlighted many areas that still require further improvements to be made we were confident that the provider would continue to monitor the service and drive forward the improvements required.