Prime Life Limited

Westerlands Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Westerlands Care Centre comprises of two buildings: Elloughton House and Brough Lodge. Brough Lodge is split into three units: The Garden Suite, Humber Suite and The Ridings Suite. Together the two buildings provide a total of 62 places to older people requiring nursing or personal care. Some people may have memory impairment and one unit in Brough Lodge cares predominantly for people with needs that challenge the service. All rooms are single with en-suite facilities: toilet and a shower. There is a large accessible garden with decking area, patio furniture and space to walk. There is ample car park space available at the side of the property.

We carried out an unannounced inspection of this service on the 16 and 17 July 2016. This was to check that the registered provider was now meeting legal requirements we had identified at inspections in April 2015, December 2015 and March 2016.

There was a registered manager in post at the time of our inspection. 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 time of our inspection the registered manager was on long term leave and an acting manager was in post covering their duties. We have referred to the acting manager as 'the manager' throughout this report.

Following our inspection of April 2015 the registered provider was found to be in breach of regulations pertaining to good governance. At the comprehensive inspections of the service in December 2015 and March 2016 we found the registered provider had failed to achieve compliance with this regulation. During this inspection, although there were signs that slight improvement had taken place, there was sufficient evidence to confirm the registered provider remained in breach. Effective systems were not in place to monitor assess and mitigate risk to people who used the service or ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the comprehensive inspections of the service in December 2015 and March 2016 we found the registered provider was in breach of regulations pertaining to providing person centred care. During this inspection although there were signs that slight improvement had taken place there was sufficient evidence to confirm the registered provider remained in breach. Care plans were not appropriate and did not meet the needs of the people who used the service or contain accurate information.

At the comprehensive inspections of the service in December 2015 and March 2016 we found the registered provider was in breach of regulations pertaining to providing safe care and treatment. During this inspection we found there was a further breach of this regulation in relation to medicine management. People who used the service did not receive safe care and treatment and avoidable harm or the risk of harm was not prevented. We found the service was failing to provide safe care and treatment by the proper and safe

management of medicines. Clear and accurate records were not being kept of medicines administered by care workers. Quantities of medicines did not match what was administered which meant we could not be sure people were given their medicines as prescribed. Risk assessments did not support the safe handling of people's medicines and care staff did not have sufficient knowledge of how to safely administer people's medicines.

At the comprehensive inspections of the service in December 2015 and March 2016 we found the registered provider was in breach of regulations pertaining to meeting people's nutritional and hydration needs. During this inspection although there were signs that slight improvement had taken place there was sufficient evidence to confirm the registered provider remained in breach. People were not supported to have adequate nutrition and hydration to maintain good health and reduce the risks of malnutrition and dehydration.

At the comprehensive inspection of the service in March 2016 we found the registered provider was in breach of regulations pertaining to treating people with dignity and respect. During this inspection although there were signs that slight improvement had taken place there was sufficient evidence to confirm the registered provider remained in breach. We found staff actions did not always ensure people received respect and were treated with dignity.

At the comprehensive inspection of the service in March 2016 we found the registered provider was in breach of regulations pertaining to consent. During this inspection although there were some signs that slight improvement had taken place there was sufficient evidence to confirm the registered provider remained in breach. We found that instructions in people's care plans failed to ensure the principles of the Mental Capacity Act 2005 were followed and best interest decisions were not in place as required.

At the comprehensive inspection of the service in March 2016 we found the registered provider was in breach of regulations pertaining to safeguarding people from abuse. During this inspection although there were signs that slight improvement had taken place there was sufficient evidence to confirm the registered provider remained in breach. We found evidence that staff practices left people at potential risk of harm and that on one occasion the manager's investigation into an allegation of abuse was not robust.

At the comprehensive inspection of the service in March 2016 we found the registered provider was in breach of regulations pertaining to staffing. During this inspection although there were signs that slight improvement had taken place there was sufficient evidence to confirm the registered provider remained in breach. Staff were not provided with the skills and knowledge to carry out their roles effectively.

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.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service remains in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the registered provider's registration of the service, will be inspected again within six months. The expectation is that registered 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 registered 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 registered 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were at risk because appropriate arrangements were not in place to handle and administer medicines safely.

People were not protected from abuse and avoidable harm as staff practices left people at potential risk of harm.

People's care plans did not contain appropriate information to enable staff to support people to manage their behaviours that challenged the service and others.

Infection control practices were not followed and this increased the risk of infection or cross infection.

Is the service effective?

Inadequate

The service was not effective.

Staff employed by the service did not have the skills, knowledge and abilities to deliver care in line with people's needs.

Decisions made on people's behalf were not made in a best interests forum as required and the principles of the Mental Capacity Act 2005 were not being followed.

People were not supported to eat or drink sufficiently to maintain their health and wellbeing.

People were supported by a range of healthcare professionals, but the service failed to implement their advice and guidance appropriately.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with respect and dignity by staff.

The care and treatment of people was not always person centred, did not meet their needs or reflect their preferences.

Care staff did demonstrate patience with people and were able to communicate with individuals in a compassionate manner.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were not planned for and their care plans did not always clearly describe their needs.

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

The registered provider had a complaints policy in place at the time of the inspection.

Is the service well-led?

Inadequate

The service was not well-led.

A start had been made on the introduction of a new quality assurance system but it was not operated effectively. However, there were signs of small improvements within the service, but not enough to make them compliant with the Regulations.

People did not receive high quality care in line with best practice.

Westerlands Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 17 August 2016; it was unannounced. On the first day of the inspection the inspection team consisted of five adult social care inspectors, a specialist professional advisor and an expert-by-experience. On the second day of the inspection the inspection team consisted of four adult social care inspectors, a specialist professional advisor and an expert-by-experience. The specialist advisor had knowledge and experience relating to older people, dementia care and mental health nursing. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had knowledge and experience relating to mental health and people living with dementia.

Before the inspection we spoke with the local authority safeguarding and commissioning teams to gain their views of the service. We were informed that there were a number of safeguarding issues being investigated and that there continued to be concerns raised by health and social care professionals going into the service.

We reviewed all of the information we held about the service, including notifications, inspection reports and actions plans sent to us by the registered provider, which outlined the actions they would take regarding the breaches identified at the previous inspections. The registered provider submitted a Provider Information Return (PIR) in March 2015 which was the last time we had requested one. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 13 people who used the service, five relatives and two visiting health and social care professionals. We also spoke with 16 members of staff including the manager, deputy manager, nursing staff, senior care staff, a 'Quality Matters' director, a human resources director and two regional directors.

We used the Short Observational Framework Tool for inspection (SOFI). SOFI is a way of observing care to help understand the experience of people who could not talk with us. We observed staff interacting with people who used the service and the level of support provided to people throughout the day.

We looked at 12 people's care files, including their initial assessments, care plans, reviews, risk assessments and Medicine Administration Records (MARs). We looked at how the service used the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interests.

We also looked at a selection of documents pertaining to the management and running of the service. This included quality assurance information, audits, satisfaction questionnaires, recruitment information for four members of staff, staff induction, training and supervision records, policies and procedures and records relating to health and safety, equipment and premises. We also completed a tour of the entire premises to check on general maintenance as well as the cleanliness and infection prevention and control practices.

Following the March 2016 inspection the registered provider had engaged a management company to carry out a report into the standards within the service. During this inspection we were able to speak with the management consultant for this company and look at copies of their two audits of the service and the resulting action plan given to the registered provider.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe and if the staff assisting them had the right skills. Comments we received included, "The night staff are very good, they check on me regularly" and "I feel as safe as I can be."

At our comprehensive inspection in March 2016 we found that known risks were not managed effectively. This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had taken some action to improve practices within the service, but these were not sufficient to meet the requirements of Regulation 12. This meant the service continued to be in breach of this regulation.

Action had been taken in an attempt to reduce the number of incidents that occurred between people that used the service. We spoke with the regional director who said, "The number of incidents between people for the last couple of months were still much higher than we wanted them to be but we have given notice to people for them to leave the home and are confident that the number of incidents will be a lot lower for August 2016."

The manager told us, "We do not restrain anyone, we would use it as a last resort, but the complex and challenging people who were here before aren't any more so we don't need to use it." The manager explained, "The one-to-one input for people was not effective, the staff used to just focus on the person. Now they know to observe what is happening around them so if another person is becoming agitated [because of the person they are supporting on the one-to-one] they can re-direct the other person to stop something happening before it starts, not trying to fix it when the people are attacking each other."

However, we found that known risks were not managed effectively; for example in July 2016 15 incidents were recorded with one person being involved in six of those. In the analysis of the incidents it stated, "To continue to be seen by the CPN who visits the home on a fortnightly basis – staff are aware that 'as and when required' (PRN) medications should be administered proactively when triggers are identified so behaviours can be minimised." However, on the first day of our inspection the person and six other people were taken out of the service to a local area of interest. The staff did not take any PRN medication and subsequently could not have administered this when required. The person's daily notes stated they had become unsettled during the journey and displayed behaviours which challenged the service and others.

Plans were in place to deal with foreseeable emergencies such as the loss of essential services or staffing issues. Personal emergency evacuation plans (PEEPs) had been created for each person, which included their levels of understanding and abilities to follow instructions if the service had to be evacuated. We saw that an emergency box was situated in both Elloughton House and Brough Lodge, which included high visibility clothing and torches as well as the PEEPs, business continuity plans and relevant contact numbers. However, when we asked staff if they were aware of the pad lock code to gain access to the emergency boxes the majority of staff did not know the code so would not have been able to access the box in an

emergency situation.

Risks were not managed to ensure people who used the service remained safe. When we arrived at the service we noted that the entry codes to both buildings had not been changed since our last inspection. This meant that ex-staff, relatives and other people could gain access to the service and failed to mitigate potential risks. The entry codes were changed on day one of our inspection after we brought this to the attention of the directors.

The above information demonstrated a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

At our comprehensive inspection in March 2016 we found poor infection prevention and control practices were being used in the service. This was a breach of Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had taken some action to improve practices within the service, but these were not sufficient to meet the requirements of Regulation 12. This meant the service continued to be in breach of this regulation. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

We found that furniture and furnishings on Brough Lodge had been replaced with more appropriate items that were easier to wash and keep hygienic and clean. The dining room chairs on Elloughton House had been replaced and the new chairs were comfortable and washable. Changes to the laundry facility on Brough Lodge now meant the room had distinct clean and dirty areas to reduce the risk of cross infection, but we found the laundry room on Elloughton House required a paper hand towel dispenser fitting so that staff could dry their hands effectively.

A new infection control audit had been introduced to the service in June 2016. This comprised of tick box sheets, but the member of staff completing the audit had not recorded the score ratings or an action plan for the one completed on Brough Lodge. Elloughton House's audit completed on 26 June 2016 had some scoring recorded and the overall score was 50%, which meant they were non-compliant according to the scoring regime. Further audits carried out in July and August 2016 were similarly poorly recorded with missing scores and action plans.

We witnessed infection control practices that increased the risk of spreading healthcare related infections throughout the service. A member of staff, who was not wearing appropriate personal protective equipment, carried a red bag containing soiled laundry through the home. We raised this with the regional director who said, "They have the trollies for the transportation of soiled items and red bags, they will be reminded of the need to use them at all times."

We walked around the service and found that the disabled toilet on the middle floor of Brough Lodge smelt strongly of stale urine. There were also noticeable odours in the lounge of Elloughton House and the chairs in the lounge were dirty and stained. Weekly cleaning schedules were shown to us for both buildings, but the deep clean schedules for July and August 2016 were blank. There was also no documented evidence of when curtains or windows in the service were cleaned.

We observed staff washing up after lunch on the Garden Suite; the pots were dried on the unit using a tea-towel and then put back in the cupboard. When we asked a member of staff about this they told us, "We

always wash up after meals, there is a machine in the kitchen but this only sterilises the pots." We noted that relatives had also commented on this in the July 2016 satisfaction questionnaires saying, "Washing up takes care staff away from people using the service" and "All dishes, mugs and glasses are washed on the unit. A dishwasher would be more hygienic."

The above information demonstrated a breach of Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

At our comprehensive inspection in March 2016 we found that people who used the service were not always protected from abuse and avoidable harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had taken some action to improve practices within the service, but these were not sufficient to meet the requirements of Regulation 13. This meant the service continued to be in breach of this regulation.

Action was taken when abusive practices and poor care were highlighted. The manager told us, "A member of staff told us they had witnessed another member of staff sat with a service user on the couch, when the person tried to get up the member of staff pulled their night dress so they sat down again. Obviously the member of staff was suspended and an investigation took place."

Discussion with the staff indicated they were knowledgeable about the different types of abuse that may occur and what signs could indicate someone was suffering from abuse. Staff we spoke with were confident about reporting any concerns about people's safety and one member of staff told us, "If I saw anything I did not like, I would first go to the person involved and talk to them, then I would discuss it with the senior carer, if need be I would go to the deputy manager or manager and if nothing was done about it I would whistle blow to the helpline." Checks of the staff training plan showed that all staff apart from seven new members of staff had completed safeguarding adults training in the last 12 months. The manager told us that new staff would complete this as part of their induction.

However, we also found evidence that staff practices did not always mean people were kept safe from harm. For example, an incident occurred at one of the registered provider's other services which prompted the registered provider to produce policies and procedures to ensure people who used the service could not gain access to items of personal protective equipment, COSHH or other things that could cause them harm. During our last inspection of the service we highlighted to the registered provider that appropriate systems were not in place to ensure their internal policies were adhered to by staff. At this inspection we found that storage areas were not locked which meant people had access to equipment and other items not securely stored including a large box of disposable razors and ingestible items.

We reviewed the incidents that occurred within the service and noted one incident recorded that two people who used the service were seen in a bedroom together and as staff arrived one person was pulling up their underwear and skirt. We questioned the manager about the incident who told us the two people were known to be close and spent large amounts of time together, they also said one of the two people were known to remove their incontinence pad when it required changing. Both of the people involved in the incident lacked capacity and the manager had failed to ensure a thorough investigation was carried out to establish if both people had the capacity to make decisions about sexual activity.

The above information demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

We spoke with two people regarding their medicines. One person said, "I always get my medicines when I want them" and another person said, "They (the staff) know how I like to take my medicines."

We found the service was failing to provide safe care and treatment by the proper and safe management of medicines. Clear and accurate records were not being kept of medicines administered by care staff and quantities of medicines did not match what was administered, which meant we could not be sure people were given their medicines as prescribed. Risk assessments did not support the safe handling of people's medicines and care staff did not have sufficient knowledge of how to safely administer people's medicines.

We looked at how medicines were managed within the service and checked a selection of medication administration records (MARs). A MAR is a document showing the medicines a person has been prescribed and recording when the medicine has been administered. We also observed a medicine round taking place. The member of care staff checked the MAR against the label on the pack the medicines were contained and asked each person who used the service whether they wanted their PRN medicine, then sat with the person whilst they took their medicine. We saw they treated people respectfully.

We observed the care staff about to cut a tablet in half; this was due to the size of the tablet and the person struggling to swallow it. However, this tablet was a modified release tablet. Modified release means that the escape of the drug from the tablet has been modified in some way. Usually this is to slow the release of the drug so that the medicine does not have to be taken too often. Modified release products usually have a higher than normal amount of the drug within them and therefore if they are halved the whole dose will be released very quickly and could be dangerous. The care staff was not aware of this and said, "It is just something we do." There was no record to say the tablet could be halved. We could not evidence who granted permission to half the tablet and discussed this with the registered manager who said they had no knowledge that staff were doing this.

We observed a nurse completing their medicine round and for one person was writing 'refused' for their medicines. One of these was Levothyroxine, which was to adjust thyroid imbalance. We questioned why the nurse was not going to try again since this was an important medicine, prescribed one each day. The nurse replied, "Yes I suppose I can." The response from the nurse indicated that they did not fully understand the dosage regimes. Levothyroxine should also be administered 30 minutes before breakfast and any other medicines. This had clearly not happened.

We looked at the topical medication administration records (TMAR's) these were accompanied by a body map to show where a topical medicine needed to be applied. However, the body map did not state the name of the topical medicine. This meant that we could not identify which body map matched which TMAR. On one TMAR where a dosage for a topical medicine stated, "Apply once a day" the administration records showed the medicine had only been applied once since the 10 August 2016. Another TMAR stated that a cream needed to be applied to affected areas as often as possible. This cream had been applied only once a day and on only one day since the 9 August 2016.

We looked at 36 medicine records. We found that records showed that medicines were not always administered. For example, staff had signed to say they had administered a medicine, however the medicine was still in the blister pack. One person received 28 tablets of one medicine on the 23 July 2016, records showed that staff had administered 25 of the tablets, which meant there should have been three capsules left. However, our checks of the stock balance showed there were ten left. The majority of boxed medicines

for pain relief for example Paracetamol recorded incorrect quantities. The registered manager or staff could not provide explanations for this.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.

We were provided with one medicine audit which had taken place on the 8 August 2016. We found this audit was not effective as it did not highlight any of the concerns we found. We were told by the management team that staff were observed every six months to assess their competency to administer medicines; however this had only taken place for one member of staff. We saw no evidence in the staff training plan to indicate that nurses had received medicine training and information in their personal files indicated that all nurses had not received medicine management training since commencing employment with Westerlands.

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

We spoke with one relative who said, "Staffing levels now are fine." At the time of our inspection there were 37 people using the service, six of whom required nursing care and 31 required residential care. We looked at the dependency tool used by the manager to calculate staffing levels based on people's needs, this was completed monthly or more often as needed and indicated that staffing levels were above the minimum requirements. However, we had some concerns about staff deployment on Brough Lodge after lunch as we observed there were two care staff in the lounge area of one unit and both were providing one-to-one input with people. We saw that one person was becoming restless and agitated despite staff efforts to settle them. One member of staff then asked the other to watch this individual and left the lounge area and did not come back for 10 to 15 minutes. This put the member of staff in the room and other people at risk of harm due to the person's unsettled behaviour. This concern was fed back to the manager during the inspection who said they would speak with the staff concerned.

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

We spoke with the maintenance person and looked at documents relating to the service of equipment used in the home. These records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required. The equipment included alarm systems such as fire safety and nurse call, moving and handling equipment such as hoists and slings, portable electrical items, water and gas systems and the passenger lifts.

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

Inadequate

Is the service effective?

Our findings

People and relatives told us that the service was not effective. Comments we received included, "The staff can barely look after themselves rather than look after older people" and "Some staff are not up to standards, they (staff) have not had proper training to put into use." However, one relative said, "Communication is brilliant. I have no issues or concerns about [Name's] care. There was a meeting at the beginning of August 2016 with [registered provider] and other relatives, where problems were discussed."

At our comprehensive inspection in March 2016 we found that staff did not have the skills, knowledge and experience to meet people's assessed needs because they had not completed relevant training. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had taken some action to improve practices within the service, but these were not sufficient to meet the requirements of Regulation 18. This meant the service continued to be in breach of this regulation.

Action had been taken to improve the training taking place in the service. The training manager had reviewed and updated the training plan for the staff in the service. It showed what training staff had to complete according to their roles. There was an on-going National Vocational Qualification (or equivalent) training programme. The manager told us they looked at the overall training plan, which identified who had not completed the necessary training and asked the administrator to book the courses as required.

The service was registered to provide care and support to people who were living with dementia and although a number of people with behaviours that challenged the service had been moved to more appropriate placements since our inspection in March 2016, there remained a number of people who had complex needs. The training manager told us that they were introducing positive behaviour support training (RESPECT) as part of the actions to reduce the use of restraint in the service. The training focused on staff understanding the triggers behind people's behaviours and being able to divert them and reduce their anxieties. The training plan indicated that there were four planned training sessions for August 2016.

We saw that the registered provider had an induction programme in place that new staff were currently working through and that care staff supervisions were taking place. However, we found that the qualified staff (nurses) were not receiving regular supervisions and one nurse told us, "We have nurse meetings but it is difficult to have supervisions because we are the only nurse on shift so they cannot pull us off the floor; they do not ask us to stay on afterwards so the supervisions get missed."

Staff did not have the skills, knowledge and experience to meet people's assessed needs because they had not completed relevant training. The registered provider deemed control of substances hazardous to health (COSHH), fire safety, food safety, infection control, moving and handling and safeguarding adults as statutory topics. From the 60 staff employed by the service only 88% had completed fire safety, 50% had completed COSHH, 63% had completed food safety, 72% had completed infection control, 79% had completed moving and handling and 89% had completed safeguarding adults.

The registered manager deemed dementia care, emergency first aid, health and safety awareness and pressure care to be 'service specific' training. From the 60 staff employed we found that only 60% had completed dementia care, 55% had completed health and safety awareness and 44% had completed pressure care training.

On the first day of our inspection we witnessed two staff using an inappropriate moving and handling technique that put the person using the service at risk of harm. This indicated that these staff lacked the knowledge and skills to move people safely. This was discussed with the manager who said they would speak with the staff concerned. We observed poor infection control practices which increased the risk of spreading health related infections throughout the service. The actions of the staff member showed a lack of understanding of adequate infection prevention and control practices. We found that staff lacked the knowledge and skills around medicine management, which put people at risk of harm through not receiving their medicines as prescribed.

We observed poor management of people's dementia behaviours during our inspection. For example, on Elloughton Lodge we sat with one person who was banging loudly on their table for about an hour. The staff initially tried to distract this person, but were unsuccessful. Other people asked several times for the person to stop banging and we saw they became increasingly annoyed and agitated as the person persisted. During the escalation of the banging (which lasted about half an hour) there were no staff in the lounge area. One person threatened to punch the person making the noise if they did not stop. Eventually two staff came into the lounge and moved the person to a more comfortable seat. When we commented "Oh, you have put [Name] in the day room" the staff said, "Yes, next to [Name] that will annoy them." We spoke to the regional directors about the staffs' practice and they agreed this was unacceptable and the staff would be spoken with.

We spoke with two health care professionals during our inspection. One of them told us, "Staff are not monitoring one person's blood sugars. We have had to abandon their reassessment as the documentation we needed was not there. We cannot review people's needs if there is no evidence or documentation available. We struggle to find clear, concise and accurate records."

A second professional visitor who spoke with us said, "We asked staff to arrange a referral to the Diabetic Specialist Nurse for a review of one person's diabetic regime back in March 2016. When we followed this up in April 2016 we found no action had been taken. We then asked staff for blood sugar readings and insulin dosage information, but again nothing was received. We contacted the registered manager directly in April 2016 and explained the situation and requested that blood samples be taken and the last seven days blood sugar readings and insulin doses be sent straight away to the District Nursing team. We were assured this would be done. When we checked again in August 2016 we found no blood results or readings had arrived and therefore no assessment of their needs was completed."

The above information demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

At our comprehensive inspection in March 2016 we found that the service had not worked within the principles of the Mental Capacity Act 2005 (MCA) and people were not provided with care that was the least restrictive. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had taken some action to improve practices

within the service, but these were not sufficient to meet the requirements of Regulation 11. This meant the service continued to be in breach of this regulation.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that applications had been made on behalf of a number of people who used the service around restricting their freedom of movement. One DoLS that had been authorised by the supervisory body contained three conditions of which the staff and manager were unaware of, indicating they did not understand the documentation or had not read the authorised DoLS paperwork.

The registered provider had brought in a Management consultant company to assist them in making the necessary changes to practice in order to meet the requirements of the regulations. We spoke with the management consultant who was currently working in the service. They had updated two of the 37 care files and said that they were working towards improving the MCA documentation and had introduced new paperwork in June 2016. They told us that it was recognised in their latest audit that the service was not yet compliant with MCA but there had been some improvements since the last inspection.

We looked at three different care files to assess the quality of the MCA documentation within them. We found the MCA information was not clear and we found evidence that next of kin were signing consent forms and best interest decisions were being made by the manager without appropriate MCA assessments and best interests meetings (BIM) taking place.

For example, for one person their care plan for finances said, "[Name] does not have capacity to manage their own finances and so requires support from [Relative]." There was no evidence of an MCA assessment around this statement.

We looked at an MCA assessment completed about the decision for one person to move bedrooms from one unit to another. The person completing the assessment had recorded that the person had capacity to understand, retain, weigh up and communicate decisions, but the outcome of the assessment was, "No. Does not have capacity. [Name] has no formal diagnosis but can show signs of confusion, they do have fluctuating capacity." The BIM minutes on 22 April 2016 documented that the deputy manager and the family member of this person had made the decision to move the person to a different room. Evidence was seen that risks and family consultation were considered during the decision and use of the least restrictive option, but if a person has fluctuating capacity then the best option would be to wait until the person was able to make the decision and not use the best interests route.

Another file had a care plan that recorded "[Name] does not have capacity over their physical health." We saw mental capacity assessments had been completed for access and receipt of medical care and treatment but these were not signed or dated by the person completing them. Another care plan for finance documented that, "[Name] does not have capacity to manage their own finances." This was dated 5 July 2016 but no information about who assessed this was evident on the file. There was no details of who

completed the MCA assessment and the best interest checklist.

Discussion with staff indicated they had limited knowledge of MCA and DoLS. One member of staff told us, "I had MCA training a long time ago. I don't understand the process."

Staff said they no longer used physical restraint unless it had been agreed through a BIM. One person's care plan stated that minimal restraint could be used to provide personal care in their best interest. The plan referred to a best interest decision that had been made in a best interest forum attended by relevant professionals and other important people in the person's life. We asked for a record of the meeting and this could not be provided. The manager informed us that a nurse employed by the registered provider had attended the meeting but during the inspection they could not be contacted to provide the minutes of the meeting.

The above information demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

At our comprehensive inspections in December 2015 and March 2016 we found that the service failed to provide person centred care and treatment. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had taken some action to improve practices within the service, but these were not sufficient to meet the requirements of Regulation 9. This meant the service continued to be in breach of this regulation.

We spoke with a health care professional who said, "The behaviour charts are not completed appropriately. For example [Name's] care plan does not provide a full picture of what their needs are and how those needs could be met. PRN medicines have been administered, but the behaviour charts do not record any agitation." We spoke about the number of people with anxious or distressed behaviours had been moved to more appropriate placements and we were told, "Documentation around incidents relating to verbal and physical aggression had not been documented and paperwork was not ready when we came out to reassess the individuals. The staff are not identifying trends, patterns or triggers."

One person's daily notes highlighted that they had a history of removing their clothing, we reviewed their care plan and although this behaviour was recorded there was no guidance to inform staff how to prevent or reduce it occurring. The manager told us, "We can't recognise any patterns and don't know why they do it, hopefully the respect training staff are doing might be able to help us stop it happening." A regional director told us, "Lots of care plans do still need updating, we have developed a new behaviour management plan and the staff have completed respect training so the new care plans will reflect the training so staff have a clear understanding of how to deliver care safely."

We found the information in people's care plans was vague and ambiguous. For example, one care plan said, "Staff to encourage [Name] to stay dry during the day." However, there were no guidelines for how staff were to achieve this. Other care plans said, "For staff to diffuse the situation or offer diversional techniques," but there was no list of what these techniques might be or what worked for each person. One member of staff spoke about the use of 'doll therapy' for one person and said this worked quite well for them, but we found no evidence about this in the person's care file.

One person whose care we looked at remained in bed due to pressure sores and frailty. Their care plan for

pressure area care documented they were to have positional changes carried out by staff every two hours. Yet when we saw them on 16 August 2016 at 15.10 hours and looked at their positional chart we saw they had been in the same position since 09.00am. This was confirmed by a relative who said, "They (staff) are supposed to turn [Name] every two hours because of their pressure sores, I've been here since 09.30 and they haven't changed their position or changed them since then." This meant there was an increased risk that the person could suffer further pressure damage to their already compromised skin. This was reported directly to the senior care staff on duty who took immediate action to give pressure relief to this person.

We informed the senior carer on duty who with the assistance of another carer turned her position. This lack of care was reported back to the manager and regional directors.

The above information demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

At our comprehensive inspections in December 2015 and March 2016 we found that the service had failed to meet people's nutritional and hydration needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had taken some action to improve practices within the service, but these were not sufficient to meet the requirements of Regulation 14. This meant the service continued to be in breach of this regulation.

We received a mixed response when we asked people and relatives what they thought about the quality of food served in the service. One person said, "The food has gone downhill recently it is not up to standard. I don't get asked what I want to eat." Another person told us, "I don't really like the sandwiches, the ham is 'plastic ham' so I just have cheese." One person said, "The cook is very helpful and talks about what I might like to eat, they try to accommodate me. I sometimes have a banana, but they are often too ripe." One relative told us, "The food is very good and all home-made which is a change. At times [Name] takes to their bed and will not eat, the care staff keep going in and encouraging them to eat." However, one person said, "I don't like the food, you just get baked potato and beans." Our observations of the breakfast and lunch time meals showed that people were given choices of meals and their requests for specific food were respected where possible.

We saw evidence in one person's care file that they were losing weight and sleeping a lot more than usual. They had been seen by their GP in August 2016 for weight loss and a diminished appetite and reluctance to drink fluids. A referral to the dietician was made on 3 August 2016 due to their weight loss. A further referral was done on 15 August 2016 as their weight had reduced even more and their GP had a number of blood tests completed. The service was waiting for the results of these to come back.

We were concerned on day one of our inspection that this person's fluid chart showed they had hardly drunk any fluid (300 millilitre between 9am and 2pm) and the senior care staff told us they had rung for the GP and an emergency doctor was coming out. Their advice to the staff was to give the person as much fluids as possible. On 17 August we noted they had taken 600 millilitres of fluid between 08:00 and 11:00am. This indicated that the person would take fluids if offered them by the staff. We saw the person asleep in their chair with half a glass of orange squash at their side. Staff told us, "We give [Name] milkshakes to increase their calorie intake." However, when we checked their fluid records these showed they had only been offered one milk shake over the last seven days. The only fluids recorded as offered were tea or juice and only on two nights in the last week was this person offered fluids through the night.

We were concerned that because this person was asleep a lot of the time, they were going over 12 hours without being offered any fluid (21 hours was the longest time recorded on their charts) and also that they were not given enough calories to maintain their weight. Their care plan indicated the person should be having 1500 millilitres of fluid a day. One member of staff told us, "[Name] should be having a drink every hour, but we cannot force them. However, I have found that if I hold the cup for them then they will drink." The records we saw indicated that staff were not offering sufficient fluids to this person on a daily basis to maintain their health.

We saw that care plans were not updated when information about people's needs changed. For example, one person's care plan documented that supplementary drinks could be given. However, the senior care staff told us, "This was stopped some time ago." The deputy manager immediately updated the care plan when we spoke with them about our concerns. The deputy manager told us on day two of our inspection that nutritional information was not being shared amongst the staff and that all staff on duty on day one had received supervision to highlight the importance of this.

The above information demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Elloughton House is an attractive building set in well-kept secure surroundings and gardens which people could access independently or with staff or relatives. We were told that re-decoration was an on-going process by staff and visitors who spend many hours at the home with their relatives. The bedrooms were all individual, en-suite and personalised. Since our last inspection in March 2016 the registered provider had purchased new dining chairs to replace the broken ones highlighted in our report.

Following staff having attended RESPECT training, which focused on the needs of people living with dementia, the service had created two quiet areas on Brough Lodge, one outside and one inside. However, we noted that the layout of the internal area could be improved as we observed one lady asleep having her legs and shins knocked by another person trying to access the limited space with a walking frame.

We were told that staff had completed the 'Virtual Dementia Tour' training, which covered dementia care and the use of colours to enhance environment for those with sensory problems. However, we found that some aspects of the environment were not always dementia friendly. When we walked around Brough Lodge we saw that the environment had been refurbished with new furniture and decoration. The colour choice for The Ridings corridors, which were painted a bright pink, did not reflect current best practice for dementia environments. All the bedroom and bathroom doors were painted different colours which staff told us aided people's orientation around the service, but the vivid colour on the walls reduced the contrast between the colours on the bedroom and bathroom doors making it harder for people living with dementia to know where they were going. There was a lack of visible signage to areas such as the garden, the lounge and bathrooms, which also did not aid people's orientation. Each bedroom door had a picture of the person with a little information about themselves. A senior care staff informed us, "These are going to be changed to pictures of when people were younger and pictures of things they are interested in as they will be able to relate to those better." We noted that the lounge on The Ridings only had a velux window for people to look out of which restricted some people's view of the surrounding community.

Requires Improvement

Is the service caring?

Our findings

We asked people and visitors if staff were kind and caring. One person said, "The girls are all very nice here. We like to have a giggle." All the people we spoke with said that the staff were either "Kind" or "Lovely" or just answered "Yes" when we asked them if they were happy and if the staff looked after them well. We spoke with two visitors whose relatives were in Elloughton House. They were happy with everything and had nothing but praise for the service and the staff. They told us they spent a lot of time there with their relatives and they could come and go any time.

At our comprehensive inspection in March 2016 we found that people who used the service were not always treated with respect and dignity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had taken some action to improve practices within the service, but these were not sufficient to meet the requirements of Regulation 10. This meant the service continued to be in breach of this regulation.

We spoke to the staff about privacy and dignity training and asked them what they thought this meant for them in practice. One member of staff told us, "It is about privacy, doing personal care behind closed doors, no shouting to residents, being discreet when asking things e.g. do you need the toilet, treating people with respect."

We spent some time sat in the lounge observing staff interactions with people using the service. Whilst talking to one person we observed a male person (A) leaning over the table with their back to us. Their trousers were falling down, which was not very dignified. This was not picked up by the staff initially. There was another person (B) walking in and out around the garden with their walking frame. At this point there was no staff in the day room and the doors out into the garden had closed. Person B wanted to come in but person A would not let them. Five minutes later a staff member came in and distracted person A, but still did not assist them with their trousers. Person A then leaned over a table with their back to the two members of staff on the floor. One staff said giggling, "Look at [person A] he's doing a 'moonie'." There was still no indication of staff helping person A in respect of their dignity. This continued for about 45 minutes before we noted person A needed continence care and we informed one of the care staff. They took person A to their bedroom.

The service was not always maintained appropriately which could have impacted on people's privacy and dignity. During our tour of the premises we noted that an upstairs bathroom door lock was missing. A member of staff said, "Oh, has it fallen out again? I'll get the maintenance man to fix it." We reviewed the maintenance book and saw that another bathroom door lock had recently required replacing. This indicated that people may not enjoy privacy whilst using these facilities as without a working lock the rooms were accessible to all. Following a discussion with the directors the lock to the bathroom was replaced on day one of our inspection.

The above information demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

At our comprehensive inspections in December 2015 and March 2016 we found that the service had failed to provide people with person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had taken some action to improve practices within the service, but these were not sufficient to meet the requirements of Regulation 9. This meant the service continued to be in breach of this regulation.

On the second day of the inspection we arrived at 08:00 and saw that six people were up and dressed in Elloughton House, they were either enjoying their breakfast, engaged with staff or sitting in the lounge. On Brough Lodge four people were in the lounge eating or watching the television. This showed that people's preferences were adhered to and if people wanted to stay in bed their choices were respected.

A member of staff told us, "The new manager seems really good, they have said it's not about filling beds and getting bonuses it's about delivering the best care we can and making this a nice place to live." The manager said, "I tell all the staff this is not just where you work, it's their home so I want to see smiles on the staff's faces and positive attitudes from everyone."

Photographs of the staff working on each shift were displayed with the service. This helped people, relatives and professionals be aware of who was working and the number of staff on each shift. At all times throughout the inspection we saw staff talking to residents, appropriate touch was used and we did not hear any raised voices from staff. All interactions that we overheard were done in a pleasant manner.

We spoke with one visitor who came to see their relative. They told us, "The care staff are very kind to [Name], very respectful and understand their needs. I'm here about 20 hours a week and so I see how they treat [Name]." Care staff demonstrated patience with people and were able to communicate with individuals in a patient / compassionate manner. Those staff who spoke with us clearly showed that they knew the people using the service well. However, we found much of the information about people's likes, dislikes, preferences and wishes was not documented in their care plans. This meant it was not easily accessible for all staff to read, especially any new staff who needed guidance on the care needs of people using the service.

For example, we were talking to the deputy manager in the corridor area and one person using the service came out of the lounge and kept trying different doors on the corridor. The deputy manager told us, "Can you excuse me as [Name of person] is looking for the toilet." They explained that this was a repeated behaviour, but we found this 'trigger' was not listed in the person's care plan. The member of staff who was doing one-to-one observations with this person had not recognised what their behaviour meant, which indicated this person could suffer the indignity of incontinence through staff's lack of knowledge.

We observed one person being offered food by a member of staff, but they refused to eat it and became agitated and distressed. Their care plan for nutrition documented, "[Name] becomes agitated / upset when offered food they do not like." However, in all of the care files we looked at, including this person's, we found no evidence that staff had documented people's nutritional likes and dislikes. We spoke with the cook and found that they had a list of likes and dislikes in the kitchen, but further discussion found the list was out of date.

The above information demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

People's private and sensitive information was not stored securely. We asked the manager to provide us with notes from a best interest meeting and we were told, "I don't have them, one of the nurses does. The problem with this place is everyone keeps stuff on memory sticks and doesn't save them to the computer." If information is not stored securely and backed up appropriately it increases the risk of it being lost or unobtainable.

Information on advocacy was seen on display in entrance hall. Advocates can represent the views of people who are unable to express their wishes. We saw that the majority of people had families who acted as their advocate, but independent advocates had been used for some people during the DoLS process.

Requires Improvement

Is the service responsive?

Our findings

At our comprehensive inspections in December 2015 and March 2016 we found that the service had failed to provide people with person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had taken some action to improve practices within the service, but these were not sufficient to meet the requirements of Regulation 9. This meant the service continued to be in breach of this regulation.

There was recognition from the registered provider that the management approach to assessing people's needs required further development. The regional director told us, "We have learnt so much, we looked at the issues we had and how we could prevent them happening again. Obviously we can't bring new people into the home at the moment but when we can we will look at their needs, the needs of the people who already live here to see if they will be compatible and will not take people who will affect the balance of the home."

The deputy manager told us, "When you last came there were people here who just should not have been here. Our assessors were coming back [after completing reviews of people's needs] and saying we shouldn't take them, they are too complex but the management just wanted to get more people in so that's what we did." A member of staff clarified, "They [the registered provider] pay bonuses for being full and that's all the [the management team] cared about so we were bringing new people in when we couldn't meet their needs and it caused all the problems you found at the last inspection." The regional director said, "We did reviews on the people who were always involved in incidents and we simply could not meet their needs. The staff couldn't manage their behaviours and they antagonised each other so we had to change things."

We found that there was a lack of detail in people's care plans, which could lead to people receiving inconsistent support that was not delivered in a person centred way. Care plans did not reflect current needs and lacked appropriate guidance to enable staff to support people effectively. This meant the service was not responsive to people's needs and put people at risk of receiving inappropriate and ineffective care.

For example, one care file we looked at documented that on 24 March 2016 staff recorded, "Please can [Name] have a referral made to falls team. Can we have correspondence with the GP and family regarding a best interests meeting for use of the recliner chair as they lack capacity and need to have their legs elevated." This followed on from an assessment review held on 24 March 2016 when staff were asked by the health care professional that information from the review and best interests meeting regarding the recliner chair were added to the care plan. We checked the care plan dated 22 March 2016, this had not been updated to include information about elevating the person's legs in a recliner chair and there was no evidence that a best interests meeting took place.

Another care plan recorded, "[Name] requires assistance with dressing." However, there was no further guidance for staff to say what support was needed or how it was to be provided. A further care plan around

mental health needs recorded that, "[Name] has dementia which impacts on their daily living and has led to [Name] lacking insight into risks." The care plan made no reference to what anxieties or distress this person may exhibit and there were no details on how care staff should offer this person reassurance. We noted that this individual was constantly calling out during the inspection.

The activity programme in the service was dependent on the staff to carry these out, as a consequence when staff were busy these did not always take place. A lot of people spent large periods of time without any meaningful engagement. Checks of the care files and discussion with the staff indicated that the recording of activities taking place was poor and people's preferences were not always met.

After lunch we observed two relatives and staff singing songs with people who appeared to be enjoying it and singing along. We asked the people who went on the trip to East Park if they enjoyed it. They said it was, "Alright." We spent some time sat in one of the lounges observing life in the home. We noted that apart from the brief pamper session taking place, all other interactions between staff and people revolved around the offering of cups of tea and snacks. One gentleman received no interaction except for his cup of tea. The garden door was locked on the second day of our inspection, which restricted people's ability to walk with purpose within the secure outside area.

One relative told us, "The care staff often put DVDs on for [Name], their favourites are The Secret Garden and Dads Army. The minister comes once a month and if [Name] cannot attend the church service they come through to [Name's] room. A lady comes from the church to chat and sings hymns with the minister. Sometimes two or three church visitors attend."

Although three of the four staff on The Garden Suite were on one-to-one duties with people, we did see one member of staff sat with a book talking to one person and we saw two other people engaging with dolls and the staff were talking to these people about their 'babies'. The staff on The G had put together 'rummage handbags', but we did not see these being used. There was a small lounge with some artefacts kept in there, but throughout the two days we only saw one person using that room – they were asleep. One member of staff told us that a certain person who used the service had a tendency to pick items up and throw them out of the window so some items were not on show. This deprived other people from being able to pick up objects.

The above information demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The service had made some improvements towards evidencing that people or their families were involved in the development of the care plans. Although many of the people living with dementia on Brough Lodge lacked capacity to contribute to their care plans, we saw evidence that families who had power of attorney had signed the care plans to say they agreed with the information recorded in them. Two relatives told us, "We have been consulted about our relative's care and can talk to the staff about changes we would like during the review process and on a daily basis" and "I have recently been involved in doing [Name's] care file. I sat with the deputy manager and went through the care plans to make sure they were done properly and there were no mistakes." Staff told us, "There is lots of training going on", "The senior staff have been given training on updating care plans" and "It is a lot better now with just little changes put into place. We have more understanding of what staff need to put into the paperwork because we have been given training on this."

The registered provider's complaints policy and procedure were displayed within the service. This included

information on how to make a complaint, the response times and what action people could take if they felt the response to their complaint was unsatisfactory. Our checks of the complaints record held by the manager showed that from January 2016 to April 2016 there had been nine complaints made to the service. We saw that since the registered provider had brought in the management consultant firm and had started making changes to the service there had been no further complaints made. Relatives who spoke with us said they were confident about using the complaints system. One relative told us, "If I have any small problems the deputy manager will sort it out immediately. They always answer my emails." Another relative said, "Because they have a good manager now it feels different. My relative is really well cared for, if they were not then they would not be here."

Inadequate

Is the service well-led?

Our findings

At our comprehensive inspections in December 2015 and March 2016 we found that the service had failed to operate good governance systems. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that the registered provider had taken some action to improve practices within the service, but these were not sufficient to meet the requirements of Regulation 17. This meant the service continued to be in breach of this regulation.

The new manager joined the service in June 2016 having worked for the registered provider for the past four /five years. They told us they had previous management experience as a unit leader. There had been a change to the regional director at the service and now two regional directors visited the service two or three times a week. The service was working to a Careport [Management Company] action plan which was updated weekly by one of the directors and overviewed by the Careport consultant. The manager told us, "We have been supported by Careport and have changed the way we audit, the old audits didn't really make sure things changed and the new ones do."

The manager told us, "Our nominated individual has been so supportive since I have been here, they have said anyone we can't meet the needs of we can find a new placement for, it's about doing the best we can for the people who live here and when we have got things right we can look at bring more people in again; but only the right people." A regional director said, "We have been told we can have anything we want for the service, more training, new equipment anything, we are committed to turning this place around. We know we can do it."

The manager told us the culture had changed within the service, they said, "The directors we have now work so differently to the old director and I am so different to the old manager. I make sure I get out of the office and see what is going on." Staff told us they found the new management team supportive and approachable. One member of staff commented, "Things have really changed, we can speak to the new manager and they will take action immediately. Things are changing and we can all see the improvements."

The deputy manager told us, "There has been huge changes, some of the staff have left, all the new staff want to work here, want the best for everyone and are committed to turning this place around." The manager said, "We lost lots of staff, some have chosen to leave because they didn't want to change, some have had to go because they couldn't do things the way we wanted. I am pleased they have gone because I know everyone here wants to do things right and look after the people who live here."

The Careport consultant told us, "When I came here I started an audit and didn't even finish it, the issues highlighted in the report were accurate and I was just wasting time so then started to look at what we needed to do to improve things. The auditing has changed drastically, things have been broken down, there used to be an accidents, incidents and falls audit which we have spilt into thee audits so we can clearly see what issues we are having and take more effective action." They also said, "The directors now sign off all

accidents, incidents and any safeguarding's."

However, we reviewed the incident reports and found that they did not always contain enough information or provide a comprehensive description of what occurred. We discussed our concerns with the regional directors who told us, "I agree with you there, we will make sure that the manager always clarifies what has happened to ensure we have an accurate record and that we have taken the action we need to." The manager told us, "The biggest issue we have here is the recording, staff don't always record things as they should and then we don't have the evidence to show what we have done."

The Careport consultant was in the process of auditing the progress of the service. They had completed two of the new care file formats as guidelines for the rest of the staff to follow. However, we found the other care files still contained out of date and poorly detailed information that did not reflect people's current needs and did not ensure they received person centred care.

New quality assurance documentation had been put into place which included new formats for recording nutrition and accident and incidents. However, the accident and incident analysis for July 2016 did not include the times of incidents so was not as effective as it could have been at identifying trends and patterns to the incidents. The food and fluid charts we saw were poorly completed and staff were not taking responsibility for these and checking them on a daily basis.

We saw that there was new supervision planner in place, but we highlighted to the manager that the qualified nursing staff were not receiving supervision on a regular basis.

The Careport consultant had introduce a weekly action plan for the manager and new paperwork for recording health and safety checks, falls risk assessments, medicine audits, choking risk assessments and bed rail assessments. New management tools included a 24 hour report form and guidelines for the care leader responsibilities and key performance indicators. However, these documents were only just beginning to be used and were not fully effective. For example the recent medicine audits had not picked up the problems we found during this inspection, which led to a new breach of Regulation 12.

Discussion with the staff indicated that communication between the staff team and management team could be better. For example we were told that information crucial to the effective evacuation of people from the service in a time of crisis was to be found in the SOS trolley's in each building. When we asked the senior staff on duty for the code for the padlock on the trolley we found they did not know it and also did not know what was in the trolley. Staff told us that, "Handovers are not very detailed, we just get told 'had a settled day, good fluid and diet taken'. The handover sheets do not have enough space to write more things on them." We were also told that, "Ambulances turn up for hospital appointments and the care staff know nothing about it, so senior care staff or the manager have to juggle staff around."

The deputy manager clearly knew all about people's behavioural triggers, historical background, likes and dislikes and they were passionate in the way they spoke about the service, but due to their management duties they could not spend all their time doing hands on care. One relative told us, "The new management that have come in are really making in-roads to the problems the service had, especially the deputy manager who is amazing. The deputy manager is very 'hands on' and you see them about the place and they are so passionate about the changes they are making." However, we found that the knowledge the deputy manager and some of the other care staff had about people using the service was not reflected in the care plans. This meant people did not always receive care in the way they wanted to and that the care being given was not reflective of their needs.

Feedback from people who used the service, relatives and staff was obtained through the use of satisfaction questionnaires, meetings and one to one sessions. In the front entrance of the service there was a notice board with a time table of meetings such as residents meetings once a month, relatives meetings once a month and staff meetings every two weeks. It was not very visible behind the door. One relative commented, "Had a positive relatives meeting with the new manager. They gave us insight and information into what was happening within the home." We were given copies of recent meetings which indicated that people, relatives and staff were encouraged to voice their opinions of the service and received some feedback from previous issues raised with the management team. We saw open and honest responses from relatives to the July 2016 satisfaction questionnaires, but at the time of our inspection the responses had not been analysed or reported on by the registered provider.

We asked for a variety of records and documents during our inspection. We found that the storage of these was not always secure. A number of documents containing personal information were kept in the nurses stations on Elloughton House and Brough Lodge. On two floors of Brough Lodge we found the doors to these areas were left open and filing cabinets were not locked. This meant anyone had easy access to these documents indicating there was a lack of security and confidentiality.

The above information demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to protect people against the risks associated with the unsafe use and management of medicines by the inappropriate arrangements for recording and handling of medicines used for the purposes of the regulated activity. Regulation 12 (1) (2) (g)