Embrace (UK) Limited

Hawkesgarth Lodge

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

Summary of findings

Overall summary

The inspection took place on 13 and 14 of December 2016 and was unannounced. The service was meeting all regulations at our last inspection in April 2015. At this inspection we found breaches of Regulation 10 Dignity and Respect, Regulation 11 Need for consent, Regulation 12 Safe care and treatment, Regulation 14 Meeting hydration and nutritional needs, Regulation 15 Premises and equipment, Regulation 17 Good Governance and Regulation 18 Staffing. You can see what action we told the provider to take at the back of the full version of the report.

Hawkesgarth Lodge is a care home with nursing for up to 48 adults living with dementia. There were 27 people living at the service at the time of the inspection.

There was no registered manager employed as they had recently left the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A peripatetic manager was working in the service to provide management support to staff. A peripatetic manager moves from one service to another whenever a need arises.

Risks to people had been identified but the written assessments did not reflect the practice of staff. Risks were not adequately managed. Accidents and incidents were not recorded consistently.

People were at risk of infection. The service was unacceptably dirty.

Staff were recruited safely but there were insufficient numbers of staff on duty to meet people's needs effectively.

Servicing and maintenance of the environment had been carried out in a timely manner.

Training was up to date but had not been embedded over time into staff practice. Staff had not been supported appropriately but since the arrival of the manager each member of staff had received supervision at least once.

The principles of the Mental Capacity Act (MCA) 2005 were not fully understood by staff and the correct process for making best interest decisions had not been followed.

The chef was knowledgeable about people's dietary needs and the food we saw was nutritious. The chef was aware of how to fortify diets and provided fortified drinks and finger foods for people. However, care staff practice and supervision was poor when serving and assisting people to eat and drink.

Staff were described by people as being caring and we saw kindness shown to people by staff. However,

they did not promote people's dignity or meet people's basic care needs through the care they provided.

Care plans did not reflect the care we observed being provided by staff.

Activities took place over five days and they were not meaningful to people living with dementia. There were no stimulating activities for people and no books or magazines to look at.

The environment was not dementia friendly and did not reflect current good practice guidance.

People knew how to make a complaint and we saw that where complaints had been made they were dealt with in line with company policy.

Notifications had been made to CQC when required.

There had been a lack of effective leadership and management at the service which had led to a significant deterioration in the quality of the service. This was being addressed by the registered provider but there were still areas of concern.

The quality assurance system was not effective. The issues found at the inspection had not been identified through auditing and monitoring. These issues had been identified in an action plan which the manager was using to demonstrate where improvements were being made.

The overall rating for this service is 'Inadequate' and the service is therefore 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 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.

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.

Risks to people's health and well-being were identified but, plans to mitigate the risks were not always followed by staff.

People were at risk of infection because the service was not clean and tidy.

Staff were recruited safely but there were insufficient staff numbers to meet people's needs effectively.

Medicines were administered safely but there were shortfalls in the way in which topical medicines were managed.

Is the service effective?

Inadequate

The service was not effective.

Training was up to date but staff practice demonstrated it had not been embedded. Staff supervisions had not been carried out for a long period but had been reintroduced.

People's nutritional needs were met but staff practice when assisting people to eat and drink did not follow good practice guidelines.

The environment was not dementia friendly so did not meet the needs of this client group.

Is the service caring?

Inadequate

The service was not caring.

We saw variations in the care provided to those people who were able to access communal areas and those nursed in bed. People's dignity was not supported through the care they received.

People's personal hygiene and appearance had not been managed well by staff.

Feedback about staff was positive as people saw them as doing their best. We saw some positive interactions between staff and people who used the service.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans did not reflect the care people received. Care prescribed by healthcare professionals had not always been implemented immediately.

Activities were not meaningful and were not provided every day. A newly employed activities organiser had begun to introduce more activities.

People knew how to make complaints and we saw that complaints were dealt with in line with company policy.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager. The lack of effective leadership had been identified by the registered provider and management support had been arranged.

The quality assurance system 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 in a timely manner in line with regulatory requirements. This was now been addressed by the peripatetic manager.

Hawkesgarth Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 14 December 2016 and was unannounced. The inspection team on day one comprised one adult social care inspector, one inspection manager, a pharmacy inspector, one specialist advisor whose specialism was mental health nursing 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. They had experience of both health and social care services. On day two the adult social care inspector returned alone.

Prior to the inspection we reviewed all the information we held about the service. The registered provider completed a Provider Information Return (PIR). 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. In addition we looked at all the statutory notifications we had received. 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.

During the inspection we case tracked three people, looking at their care plans, medicine records and other documentation in relation to their care. In addition we looked at a further three care plans. We also inspected the way in which medicines were managed by reviewing six medicine records and reconciling them with the prescription and stock, observing how medicines were administered and checking the storage of medicines. We observed a lunchtime period and people being given assistance to eat and drink. We reviewed other documents relating to the running of the service such as accident and incident records, general risk assessments and servicing and maintenance documents.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. There were very few people who could speak with us and give feedback.

We spoke with six people who used the service and four relatives during the inspection and a further five relatives and friends following the inspection. We also spoke with a chiropodist and a social worker during the inspection. We interviewed the clinical lead nurse and a registered nurse who were on duty during the inspection as well as speaking with an agency care worker, a domestic worker, a maintenance person, a chef and a kitchen assistant.

The peripatetic manager made themselves available throughout the inspection answering our questions and providing information promptly.

Following the inspection we spoke with a community mental health nurse, community mental health team manager, a palliative care clinical nurse specialist, a practice nurse from one of the surgeries used by people at the service and an independent mental capacity advocate. We contacted a further 14 care workers after the inspection as staff were very busy on both days of the inspection. We left them a message with our contact details and three staff gave us feedback.

The provider readily agreed to an early meeting following the inspection in order to discuss our findings. We met them on 4 January 2017 which was the earliest mutually convenient time.

Inadequate

Is the service safe?

Our findings

We inspected this service because of the number of concerns raised with North Yorkshire County Council (NYCC) about people's safety. These are called safeguarding alerts and had been made to NYCC, which has responsibility for investigating any matters relating to safeguarding adults in this area. There had been 56 safeguarding alerts made between April 2016 and the date of this inspection. 52 alerts had been substantiated. This meant that when they were investigated evidence suggested that the allegations were true. The information was shared with CQC and raised potential concerns about how people's care and personal safety was managed and about the management of the service. We looked at these issues during the inspection.

Hawkesgarth Lodge had been involved in NYCC collective care procedures and concerns had been raised in respect of the following areas; inadequate record keeping and care planning, documentation not being completed correctly, staffing levels, and concerns regarding poor leadership within the service. NYCC had recently been visiting people at the service weekly. In addition, the community mental health team who had patients living at this service had been visiting weekly to ensure their well-being.

During our two day inspection it was necessary for us to ask the manager to make three individual safeguarding referrals to NYCC. We made a further five safeguarding referrals to NYCC following the inspection. The concerns we identified related to a lack of appropriate care and risk management. The registered provider had been working with the local authority and healthcare staff by supporting their investigations and attending meetings. Appropriate safeguarding policies were in place. These policies helped ensure the correct management of any allegations of abuse. Over 90% of staff had received training in recognising abuse and knew who to alert if they witnessed any incidents.

People who used the service did not comment directly about whether or not they felt safe but made comments such as," There is always someone in the vicinity" and "They [Staff] answer call bells in a reasonable time." This indicated that they felt safe. Relatives gave mixed feedback about people's safety. One relative said, "It goes up and down really. It would be nice if we could get some permanent staff" and another said, "I haven't any qualms about safety as doors are always locked. I do feel there should be more staff because she is left alone a lot. I don't think they know I have visited [referring to their last visit]."

Risks to individuals had been adequately assessed and risk management plans were in place but the care we observed did not always correspond with what was recorded. This meant people were at risk of avoidable harm because staff were not following the plans for people. For example, people had correct assessments and equipment in place to mitigate risks to their skin but we found two pressure relieving mattresses set incorrectly. One person who weighed 47.5 kgs on 8 December 2016 and was at risk of pressure damage had their mattress set for a person weighing 110 kgs. A second person who was also at risk of pressure damage had a mattress that was also set too high. This meant those people were at risk of further pressure damage.

We noted several people with substantial weight loss. The malnutrition universal screening tool (MUST) had

been used to assess their risk but the guidance within this risk management tool had not been followed. For instance, one person had unexplained weight loss of 9.9 kgs over two months. This was 11.3% of their previous weight. The guidance suggested that they should have been referred to a healthcare professional. While this may have been a recording error we could not confirm that this matter had been investigated..

Medicines were stored securely and access was restricted to authorised staff. Unwanted medicines were disposed of in accordance with waste regulations but there were excessive stocks of topical applications such as creams found in people's rooms. Controlled drugs (CD's) which are medicines that require extra checks and special storage arrangements because of their potential for misuse were stored in a CD cupboard. Access to them was restricted and the keys held securely. Staff carried out regular checks to ensure balances of CD's were correct. We observed nursing staff administering medicines with care and compassion. The nurse's approach to giving medicines was tailored to the preferences of each individual service user.

Room temperatures where medicines were stored were recorded daily and were within safe limits. We checked medicines which required storage in a fridge and found gaps in recording and temperatures which had been recorded outside of the recommended range on four days in November 2016. This had not been escalated in accordance with the home's policy.

Some people were prescribed medicines to be given 'when required'. We found protocols were not always in place to guide staff on when and how to administer these medicines. In addition, staff did not always record their reasons for administering 'when required' medicines. We checked records for two people who were prescribed 'when required' laxatives and found bowel charts had not always been completed correctly. This meant staff may be unable to tell whether people had needed to take their laxatives or not.

We were concerned about the administration and recording of topical medicines, such as creams and shampoos. Topical medicine administration records (MARs) were not always completed so we could not be sure people had received their treatment as it had been prescribed. We checked the records for one person who was prescribed a shampoo to treat a scalp condition. The topical MAR indicated this had not been applied at all in November or December 2016. In addition, we found two bottles of this shampoo in the person's room dating from May and September 2016. This suggested the treatment was not being applied as it had been prescribed. Topical preparations were left unattended in people's rooms which increased the risk of harm from ingesting them as many of the people at the service were living with dementia and may not recognise the dangers.

The manager showed us weekly and quarterly medicines audits, the last of which had been carried out in December 2016. Clear action plans had been put in place to drive forward improvements where they were necessary.

People were at risk of infection because of the lack of cleanliness at the service. When we arrived there was a strong smell of urine and the service was unacceptably dirty. There was only one domestic member of staff to clean what was, a very large building. There were basic cleaning schedules in place but these had not been completed. A relative told us, "When you walk in there is always a bit of a smell. I was concerned [Relatives] room was not hoovered" and another said, "I have noticed that hand gel [Alcohol hand sanitiser] is always empty."

We checked communal areas and each person's bedroom and found that when we walked on flooring and carpets and some were sticky and others were stained with visible food debris. In some rooms walls were marked and furniture was heavily stained. Bedside tables were sticky to touch and stained with the remains

of food and drink. Some beds were dirty with wet or stained sheets. Chairs were marked with brown staining in two rooms. High surfaces and light fittings were dusty and cobwebs were visible. Mechanical ventilation units did not work in all en-suite areas. Some people had their windows locked which restricted fresh air flow. Open packets of continence pads and aids were strewn on people's bedroom floors and manual handling aids were left on the backs of chairs. Most of the rooms we checked were untidy and some had personal items crammed into drawers which were crumpled, dirty and in poor condition. Some toilets had no paper hand towels available and alcohol gel dispensers were empty.

This meant that care and treatment at the service was not delivered consistently or safely and people living at the service were at risk of harm which could have been avoided if the registered provider had taken the action required of them to mitigate these risks. We requested a visit by the community infection prevention and control nurse which they carried out on 6 January 2017.Their subsequent report confirmed our findings. They have told us that they will be making a further visit to the service to check that improvements have been made.

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

The service did not have sufficient numbers of suitably qualified, competent and skilled staff to meet people's needs. The rotas showed the service was heavily reliant on agency staff. Staff told us, "Staffing is definitely not adequate. We are meeting ourselves coming back most of the time. I worry when I get home in case I have missed something but there are just not enough hours in a day" and "The staffing levels are ridiculous. I was so stressed and worried that I would miss something." One relative said, "There are enough staff during the week but weekends are a bit sparse" and another commented, "The last time I visited I was there for two hours but didn't see anyone." There were two nurses and four care workers to look after 28 people on the first day we inspected. In addition, there was an agency worker who told us they were there to provide one to one care for a person.

There was not enough staff to provide appropriate support to people in order that they received a proper diet. People came into the service to assist their relative with eating and drinking. Although this impacted on people's eating and drinking the root cause appeared to be a lack of guidance and supervision for members of care staff. The clinical lead nurse informed us that they did not have the time to supervise the work of the care staff.

We identified some gaps in the staff rota over six weeks prior to our inspection which showed the service had not met their own identified minimum staffing levels to enable them to deliver safe care. We had already been told by the manager that the team of four domestic staff had left the service and only one had been replaced with a second person awaiting background checks. There was currently only one chef and one kitchen assistant employed. Another chef had been employed but was awaiting background checks to be completed. We saw that when staff had been absent replacements had not always been found to cover those hours leaving existing staff to cope. For example, in one week there was one nurse on duty for 12 hour shifts over four days and on one of those days the nurse was from an agency. In the same week an agency nurse was left in charge for four night shifts. On one of those night shifts there were only two care workers on duty when the current requirement was for three care workers. One member of staff said, "There are supposed to be three carers at night. Sometimes there are only two and sometimes there are three but two of them may be agency staff. They don't know people well and so the regular staff have to manage most of the work." A clinical nurse specialist told us "Towards the end of last year there were a lot of problems with staffing."

The registered provider recognised that staffing was an issue and was advertising for all vacant posts. The service is in a rural location with limited access to potential staff because of its location. This had been a recurring problem within the service and one which the registered provider was working to address. In addition a large number of core staff had left the service over the past six months leaving a higher than usual number of new staff with limited experience of people and their specific needs. Combined together these factors put people at risk.

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

People were recruited safely. Application forms were completed, interviews organised and background checks had been undertaken before staff began work. Staff recruitment files showed two references recorded and checks by the Disclosure and Barring Service (DBS). DBS checks give information about any convictions, cautions, warnings or reprimands and check whether or not people are barred from working with certain groups. They help employers make safer recruitment decisions and are designed to prevent unsuitable people from working with adults who may be vulnerable.

Servicing and maintenance checks of the premises had been completed in house and by external contractors in a timely manner. These were recorded. Fire safety checks had been completed. One of the weekly tests of the fire alarm was carried out during the inspection. The last fire drill was in November 2016 and these were carried out on a monthly basis. Window restrictors were in place and checked monthly along with monthly checks of other areas such as call bell systems. Servicing of mains services and lifting equipment had taken place within the last 12 months. There was an emergency plan in place which guided staff in what to do in the event of an unexpected event such as loss of electricity or flooding.

We made the manager, who was acting on behalf of the registered provider, aware of the multiple concerns we had during the course of our inspection. We also wrote to the provider to make them aware of our immediate concerns.

Inadequate

Is the service effective?

Our findings

People who used the service told us, "Staff know what they're doing" and "Its good care." Relatives said, "Staff seem to know what they are doing" and "They've worked wonders with [Relative]." A member of staff said, "Over the last few months we have done the best we can under difficult circumstances." Our own observations highlighted some lack of skilled practice amongst staff and we identified a number of factors contributing to this situation. There had been a lot of changes within the staff team, a lack of face to face training and competency checks which meant that training was not embedded and there had been a lack of support for staff.

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 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

People's plans of care showed the principles of the MCA Code of Practice had been used when assessing their ability to make decisions. The service also had a policy and procedure on the MCA and DoLS to protect people. However, staff did not fully understand the principles of the MCA and DoLS because they were not following the process for best interest decision making. Best interest decisions are made when someone does not have the mental capacity to decide on their care and treatment. These should include family, friends and relevant professionals in order to find the best outcome for a person. The service had not followed this process. Some people had an Independent Mental Capacity Advocate (IMCA). This is a person who has been appointed by the local authority to represent someone's interests. However, they had not been included in the best interest decision making process.

Although staff were able to tell us about best interest decisions that had been made they acknowledged that decisions about people's care and treatment had been made internally without input from any other parties. This meant that they were not valid decisions. For instance, decisions about one person's care had been made with no input from family or health and social care professionals which meant that the people who knew the person best had not contributed and what the person themselves would want had not been discussed.

Some people were being given their medicines covertly (disguised in food or drink). We checked care records and found that the process for deciding whether or not covert administration of medicines was appropriate through best interest decisions meetings had not been followed correctly. Involvement of the

person where possible, and consultation with relatives and others as appropriate (in this case the GP and pharmacist) is an essential part of best interests decision making under the MCA and protects peoples human rights.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 – Need for Consent

The manager told us they had applied for a number of DoLS authorisations, and some had been granted. Other applications had not yet been assessed by North Yorkshire County Council. Records confirmed these had been applied for and the decisions had been made in the person's best interests.

There was a lack of evidence of consent or approval by appropriate representatives in respect of all care and treatment. The only signatures were those of care staff which is not reflective of good practice guidelines. Where appropriate, Do Not Attempt Cardio Pulmonary Resuscitation consent forms (DNACPR) were correctly completed with the relevant signatures. .

We spoke with the chef who was very knowledgeable about people's dietary requirements. They kept a record of people's likes and dislikes as well as how people required their food to be presented. Some people required their food to be pureed or soft. The chef was aware of the need to fortify people's food and told us they provided milk shakes twice a day, snacks for people and fortified foods with butter and cream where appropriate. This good practice was not consistent with the weight loss we had noted and we observed a lunchtime period to see how staff managed mealtimes.

Tables had table cloths and condiments. The food was served from a hot trolley by a member of staff. In the trolley the food looked appetising. However when the meals were served we saw that different components of the meal had all been mixed together which made the meal look unappetising. We saw that the organisation in the dining room was confused. One person walked constantly without purpose. When a member of staff indicated they should sit in a chair they pulled out for them they went towards the table, but then the staff member walked away causing some confusion for the person who then walked on. They had not eaten anything during the thirty minutes we were observing and no staff encouraged them to do so. Staff left sandwiches in people's rooms which we saw were still there untouched after lunch.

We saw that drinks were taken around during the morning and afternoon. However, people were not supplied with their milk shake drink on the second day of the inspection. Food and fluid charts were in place for some people but the recording of fluid intake particularly was poor with charts not completed. People were not always receiving adequate fluids. The Association of UK Dieticians recommends that women drink an average of 1600mls of fluid a day and men 2000mls. One person had only had 250mls of fluid recorded at 3.30pm which was not adequate. We found fluid chart entries were not 'totalled up' at the end of each shift and analysed by nursing staff to identify where people should be given further fluids throughout the next shift to ensure they did not become dehydrated.

We noted substantial weight loss for some people in records completed by staff at the service between April and December 2016. Some people had been referred for assessment but others had not. Staff told us that because one person's body mass index (BMI) was more than 18 they did not consider it appropriate to refer to the person's GP despite the weight loss being unexplained. The body mass index (BMI) is a measure that uses your height and weight to work out if your weight is healthy. A body mass index of 18.5 or below is considered to be underweight but to determine if this was a health risk a healthcare provider would need to perform further assessments. We spoke to the practice nurse at the main surgery used by this service who told us "I would expect staff to discuss high weight losses or unexplained weight losses with me so we could

decide together what action to take." This meant that risks to people's health which had been identified were not been acted upon in all cases. However when we looked at how the risk had been determined we saw that only two people were affected. We did see that speech and language therapists had assessed some people.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.- Meeting nutritional and hydration needs

There were snack baskets available in the communal rooms which contained fruit, crisps and biscuits that people could eat throughout the day. Some people were enjoying eating some fruit.

The environment did not support the needs of people living with dementia and did not support good practice. The standards of bedrooms varied from personalised to bare and uninteresting. Although initially the service appeared to be based on a square so that people walking would return to the same place we discovered this was not so. There were additional corridors and dead ends which would cause confusion to someone living with dementia. There was no colour contrast or personalisation of bedroom doors with customised signs to identify the person's room using names and photographs or personal objects. This was not helpful for people in retaining independence in finding their own way to their room.

There was no signage to aid way finding and promote people's independence in moving around the service. Disorientation and bewilderment are a common experience for people with dementia. Signs can be very helpful if they are clear, mounted low enough, have words and a picture and contrast with the background.

There was enough light but no colour contrast to allow people to see properly. Contrasting colours had not been used in order to highlight important areas. For instance toilet doors and seats can aid continence if contrasting colour is used.

There were no themed areas around the building to provide a topic of conversation for people and no rummage boxes or identified drawers that people could open and explore. There were no pictures on the walls. The manager told us they had been taken down so that the service could be decorated but the subsequent decor had not been made dementia friendly through the use of colour. Pictures can help people living with dementia communicate if they are set low enough.

There were several small gardens which were accessible for people and safe. They had not been designed for people with dementia. The paths were not well defined and there were no handrails beside the paths. The gardens had not been designed using peoples preferences and memories.

One member of staff told us, "It [Service] is not conducive to a happy environment. It needs welcoming, stimulating colours. It is drab and miserable. I do not think the décor is dementia friendly." We observed that people did not appear stimulated. One person was distressed and saying they wanted to go home and another walked around person was sat alone in a lounge. There was nothing within the environment to stimulate them.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations –Premises and equipment.

After the inspection the provider assured us of their early intentions to review and upgraded the premises to ensure that they supported and enhanced the needs of people who required specialist dementia care.

We asked the manager how people were supported when they started working at the service. She told us that inductions had not been thorough prior to their arrival in September 2016 but staff were now receiving a thorough 12 week induction and the Care Certificate had been introduced for staff to support this. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

Staff had received training in all areas the registered provider considered mandatory. This included areas such as fire safety, dementia, health and safety and moving and handling. Training was provided through eLearning so there was no face to face contact with trainers. A high percentage of staff had completed their training but newer staff were still completing their training. The company trainer was now spending time at Hawkesgarth Lodge to ensure staff were supported in their training. We did not see any competency checks completed by senior staff which would have enabled theoretical training to become embedded in staff practice.

A community psychiatric nurse told us when discussing the care of people living with dementia, "Care staff are not well trained and nurse's skills vary. However, I did recently highlight the good practice of a bank nurse to the manager at Hawkesgarth Lodge." The practice nurse from a local surgery said, "They have had some good agency staff. I have not seen any particularly bad care but appreciate that care has not always been great."

Staff had not received any supervision between May and October 2016 but this had been re-introduced by the peripatetic manager. All staff had received supervision in November. The manager told us this would now happen on a regular basis.

Conditions which required monitoring were managed in consultation with people's GP's or the community mental health team. We met a chiropodist and a social worker who were visiting people at the service. A detailed staff handover between shifts had been introduced recently so that staff were aware of any changes in people's care needs and whether there was any information to share from health care professionals. GP and other health care professionals visits were clearly recorded which meant that communications around people's health were easy to monitor. The support guidelines from professionals were written into care plans but these were not always followed. For example a community psychiatric nurse told us, "We have had some battles with staff to get the care people need. We asked staff to put someone on bed rest and turn bed to window [So that the person was looking out of a window]. It took several attempts and conversations with staff to make it happen."

Staff supported people to attend hospital appointments but did not always communicate this to relatives. One relative told us, "They took [Relative] for their [Name of condition] check but staff didn't let me know. I would have liked to go with him. "

Inadequate

Is the service caring?

Our findings

One person who used the service described staff as "Dedicated carers." Relatives told us that staff were kind. They said, "They [Staff] are really good" and "They are very nice and are always friendly." However, we saw a variation in the quality of care and support provided to people who were in the communal areas and those nursed in bed. People in the communal areas had staff chatting to them throughout the day as they passed but those in their bedrooms were left alone often behind a closed door. The clinical lead nurse told us, "The only time I have to check on people is when I give them their medicines."

Staff did not always promote people's dignity because they were not thoughtful about the care they provided. We saw that one person was nursed in bed. Their drink and dessert had been left on the bedside table but this person had bed safety rails and so could not have reached them. There was no member of staff to help. Another person was laid in a dishevelled state on their bed. They had crusting around their eyes and their hair was dirty and matted. They had a severe scalp condition and looked as if their care had been disregarded. Staff had not supported people to maintain their personal hygiene and appearance.

We were given copies of records by the manager that suggested that at least two people had not received a bath or shower since October 13 2016. This meant that their personal hygiene was not attended to which did not support their dignity. When we explored this with staff they were unable to confirm when these people had been fully bathed.

People had no hairdresser to look after their hair. As a result we saw that people's hair was lank, greasy and looked dirty and had not been cut or styled. One relative told us, "Quite often [Relative] doesn't have her hair washed. I do her nails because they get dirty. If I bring it up they say they were clean a few hours ago." A second person told us, "[They] looked in a bit of a state with dirty hair and feet." We saw that one person's care plan said they liked to keep their hair short and styled. We saw the person's hair was long and they told us it was 'irritating the back of their neck'.

People's environment was dirty and not cared for and did not support the fact that they were living with dementia. A person's appearance is integral to their self-respect and older people need to receive appropriate levels of support to maintain the standards they are used to. The staff at Hawkesgarth Lodge were not supporting people's wellbeing

We saw one member of staff demonstrate good practice when assisting someone to eat and drink. They were concentrated solely on the person, showing them respect and treating them with dignity. A second person was being assisted to eat by another member of staff. They [Member of staff] started to feed the person and then stood up and walked across the dining room to chat to someone and help another person. This was disruptive for the person and did not make this a pleasant dining experience for them. This did not promote the dignity of the person who needed support

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

We did see some positive interactions in the communal areas with staff speaking to people in a kindly manner. We heard one member of staff have a conversation with someone about their family showing their knowledge of the person. They noticed that this person had on a cardigan with a broken zip. They suggested going to get another top and assisted the person in changing it. They checked that was acceptable to the person and were encouraging when changing the top.

One person told us that staff respected their privacy. They said, "They knock on my door to let me know they are there. If I didn't want them in my room I'd tell them to get out and they would." A second person told us, "Staff knock on my door before they come in."

Some people had an independent mental capacity advocate (IMCA) and others had access to advocacy which could be arranged by the manager if required. One person had one to one support because they were a risk to themselves and others. This type of support allowed them to remain at the service supporting their wellbeing whilst protecting others at the same time.

There was no-one receiving end of life care when we carried out this inspection but we were told that one person had done so recently.We spoke with the clinical nurse specialist at the hospice. They told us that in 2015 the staff at this service had completed training in palliative and end of life care which was due to be reviewed.

Requires Improvement

Is the service responsive?

Our findings

Care planning documentation was not consistent and did not always reflect the care that was being provided to people. The files were well kept and the care plans were appropriate to people's needs in most instances. We saw evidence of good care planning and well written records. There was a good association between risk and planned support which is good practice. However, observed practice did not always reflect this.

For example, one person's care plan identified that they liked to dress smartly and appear well groomed at all times. When we spent time with them we saw they had extensive facial hair and their hair was unkempt. The person's personal care support plan stated, "Unable to shower, wash her hair without full support. [Name] has her hair short and styled after washing." The care records were up to date, relevant and person centred but the care was not being delivered.

Care plans had been evaluated monthly and some reviews of peoples care had been completed by health and social care professionals. We spoke with a social worker who was carrying out reviews on day two of the inspection. She did not perceive staff as being responsive to people's needs and gave us several examples to illustrate her view. We also spoke with a community psychiatric nurse (CPN) following the inspection who told us that staff had not always responded promptly to care prescribed by themselves.

No activities took place on the first day of our inspection. There had been a long period when the service had no activities organiser but someone had recently been employed and they were in their induction period. On day two the activities organiser was working and we saw several activities taking place which people enjoyed. The activities organiser worked over five days and we were told staff provided activities on the other two days. This did not happen on the activity organiser's day off [Day one of the inspection].

Activities we observed were in groups with people laughing and enjoying themselves. We did not see any one to one interactions take place. People nursed in bed were socially isolated. Quality statement 4 in The National Institute for Health and Care Excellence (NICE) guidance QS30 states that there should be, "Evidence of local arrangements to find out about the individual interests and preferences of people with dementia in order to ensure access to leisure activities of interest and evidence of local arrangements to ensure that people with dementia are enabled to take part in leisure activities during their day based on individual interest and choice." We did not see any evidence that the, "This is Me" documents which were in some people's care plans, were used to identify activity for people.

There were no obvious meaningful activities. People did not take part in tasks around their home. Being engaged in meaningful activity allows some of people's most basic needs, such as socialisation, a sense of accomplishment, a sense of purpose, play, as well as our need for cognitive and physical stimulation, to be met. There were no rummage boxes or items to stimulate conversation. We did not see any newspapers in the lounges or people's rooms.

One relative told us, "There has been nothing in the past months but I have now spoken to the new person

and told them what [Relative] likes doing. She loves music and singers come in." A community psychiatric nurse told us about one person saying, "There is no meaningful engagement with staff."

People knew how to raise concerns or complaints. They told us they would speak with a member of staff or the manager. We reviewed the complaints record and saw that three complaints had been recorded. They were all related to concerns from relatives about people's care and welfare. These were investigated and responded to appropriately in line with company policy.

Inadequate

Is the service well-led?

Our findings

Hawkesgarth Lodge is one of eight services run by Embrace (UK) Limited. The registered provider has demonstrated improvements in the ratings of over 50% of their registered services in the North in the last 12 months.

The registered manager for this service had recently left in October 2016 and there was a peripatetic manager at the service. They were employed by the registered provider to work in different services where there was a need. We were told by the provider that they would stay at the service until a new manager was employed and oversee their induction. At the time of our inspection they had been at the service for two months. The registered provider had begun to look for a new and suitable manager to take the service forward.

The regional manager had left the service in September 2016 and an existing regional manager from another area had added Hawkesgarth Lodge to their portfolio. They were not present for the inspection. The clinical lead had retired prior to the inspection and a new clinical lead had been appointed. There had been a lot of change within the staff team and it was proving difficult to recruit staff to the service which meant the service was heavily reliant on agency staff. They were an invaluable resource in filling gaps when staff were off sick but were often strangers to people in the service which could have an impact on people's safety and quality of care.

There had been a lack of effective leadership and management oversight at the service which the registered provider had identified before the inspection. The manager told us at the beginning of the inspection that that they were working hard to make the necessary improvements. There had been a high number of safeguarding alerts made to the local authority since April 2016 but the manager was now working with the local authority and other professionals to make improvements in this area.

The registered provider had made a voluntary arrangement with North Yorkshire County Council to suspend admissions. The registered provider had agreed that any plans to admit people would be discussed with us before anyone new was admitted.

There was a quality assurance system in place but a lot of the issues we raised had not been identified in audits completed by the service. For example, there was no mention of any of the infection control issues we had identified on either the manager's audit or the monthly registered provider visit report for the previous two months. In addition managers had not monitored the standard of care that people had been receiving. This meant that the audits and oversight of the service was not robust. This had resulted in a situation where some areas of the service had shown improvement but the basic care of people and the cleanliness of the environment had deteriorated and placed people at risk.

Accidents and incidents were being recorded in both daily notes and a central logging system. These records did not always correspond. For example, one person had two falls recorded in their daily record for one day in December 2016 but only one had been recorded in the central log. Three falls were recorded in

the accident log for a second day in December 2016 for the same person but only two were recorded in daily records. This meant that the registered provider could not be assured that the manager was aware of all of the incidents which had taken place within the service or that action had been taken to reduce the risk of incidents recurring. Therefore, risks related to accidents and incidents were not being adequately assessed or managed and meant people remained at risk of harm.

The risks relating to the health, safety and welfare of people who used the service and others who may be at risk had not been acted upon. For example, when people had substantial weight loss they had not always been referred to healthcare professionals.

Notifications to CQC had not always been made in a timely manner and the inspector had raised the matter with the provider at meetings with North Yorkshire County Council. This was now been addressed by the peripatetic manager.

The registered provider had failed to ensure that they were meeting all the Regulations.

This was a breach of Regulation 17 of the Health and Social Care act 2008 (Regulated Activities) 2014- Good Governance

Culture reflects the shared values of a service. The Embrace company website says, "The team at Hawkesgarth Lodge work in a person centred way to identify people's goals. We focus on enablement and the promotion of personal dignity in a safe and respectful environment. The people we support receive the highest standard of care that is tailored to their individual needs." However this was not what we found at the inspection. Staff and professionals gave us their feedback and our own observations were inconsistent with what the provider was saying in this statement. A member of staff told us, "The managers have not encompassed the values of the service as much as they could." Staff were not provided with sufficient direction and leadership to ensure that people received a consistently good standard of care.

The registered provider's representatives responded promptly when we wrote to urgently share our findings and concerns. They took immediate steps to rectify matters such as cleanliness and personally spent time at the service effecting change. They were clear that although they had brought in a knowledgeable manager who had a good track record in making necessary improvements needed, changes within the service would take time. They made some immediate improvements following our initial feedback to ensure people's safety and sent us an action plan to tell us what they would be doing to address other areas of concern.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff were not working within the principles of the Mental Capacity Act and did not always seek consent through best Interest decision making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety were not always identified. When they were the guidance was not followed to ensure people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People had not always been referred for appropriate healthcare support when there was unexpected weight loss. People were not supported with eating and drinking.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The environment was not dementia friendly and did not meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff in all areas of the service to meet people's needs effectively