# Benridge Care Homes Limited

# Asmall Hall

## Inspection report

Asmall Lane
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05 July 2018
06 July 2018
09 July 2018

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Good |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

We inspected Asmall Hall on the 4, 5, 6 and 9 July 2018. The first day of the inspection was unannounced. This is the first inspection of Asmall hall under the new provider Benridge Care Homes Limited. Benridge Care Homes own two other care homes in the Southport area.

Asmall Care home is a large country manor type home set in its own grounds. The home is over two floors and supports people with nursing and residential care needs. There are two units one on each side of the home with their bedroom accommodation to the ground and first floor. One unit supports people with nursing and residential needs and the other supports people with nursing needs and people living with dementia.

Each unit has its own large lounge and dining room and there is a second quiet room on each unit. There is a large kitchen providing food across the home and a large laundry in the annex to the side of the main building.

The home can support up to 56 people and at the time of the inspection there were 36 people living in the home. The new provider has undertaken a large investment programme updating and refurbishing the whole building. At the time of the inspection there were further works planned following planning permission.

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

At the time of the inspection Asmall Hall had a current registered manager who was also the nominated individual. Following the inspection the nominated individual role was taken on by a director from the provider's company. The provider was currently recruiting to the registered managers post so the current manager could revert to managing another of their services. The provider's third service was also looking for a registered manager to allow for each service to be managed by its own dedicated manager registered with the Care Quality Commission. A recommendation has been added to the report to prompt the provider to do this as soon as possible. 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.

The provider had begun to manage the service following the last CQC inspection of the home. The last inspection under the previous provider, rated the home as inadequate. The registered manager had been involved in the quality improvement programme implemented following the findings of the last inspection as many areas of concern were identified.

The new provider had bought the home as an ongoing business concern and had completed all the legal obligations of transferring staff from the previous provider to become an employee of Benridge care homes if they so wished. They had also recruited many new staff. We found recruitment procedures were fair and equitable. However, we were aware that the recruitment of staff had been difficult. This is in part because of the location of the home. We found the provider had been unable to suitably recruit enough staff with the competence and skills to deliver the nursing element of the service in line with the requirements of the regulations. We have found the service in breach of Regulation 12, safe care and treatment.

We have also found that suitable risk management plans had not been implemented. We identified risks which had not been addressed prior to their identification at the inspection. We also found where risks had been identified appropriate risk management plans had not been put in place. We found a further breach to Regulation 12, safe care and treatment, for the assessment and management of risk.

Care plans were in a period of development and there were some good documents used for assessment but these stood alone outside of the care planning system and had not been included appropriately when developing support to meet people's needs. We found many care plans which were not reflective of people's needs and were not updated with the involvement of the individual or the individual's representative. This has led to a breach of Regulation 9.

We have also made nine recommendations in the report. We found where people had when required medications administered, protocols explaining what this meant were not always in place. They did not include the detail of what the medication was for and when it should be given. There were no clear guidelines for how staff could recognise when it was required, when the person prescribed it, could not verbalise their state of health and wellbeing. We have recommended clearer protocols were put in place.

We found some contradictions between assessments and the support provided. We saw some assessments specifically around food and drink were not followed. Reasons for this were ambiguous and we have recommended the provider ensures that appropriate documentation is completed to support people's needs to be met.

We have also recommended some processes be formalised including complaints, the activity programmes and staff support including appraisals, supervisions and competency records.

We have recommended end of life assessments and care planning is reviewed and developed more comprehensively and assessments under the MCA are also reviewed and evaluated. This is to ensure they are accurate and are what is required. We have recommended the provider begins to hold resident and relative forums to gather feedback on the service delivered and lastly, we have recommended that the management structure is agreed and developed with greater clinical oversight.

People are supported to have maximum choice and control of their lives and staff attempt to support them in the least restrictive way possible; the policies in the service support this practice and work is being completed to embed systems to ensure this is implemented in line with the principles of the Mental Capacity Act.

Over the course of the inspection we saw the building interior and exterior had improved greatly since the last time CQC inspected. The provider had completed interior design based on best practice principles for homes supporting people living with dementia. We saw different dedicated space for quiet seating areas from one person to a group of people. Walls were decorated with memorabilia with a garden theme and we could see from pictures sent to the commission prior to writing this report that there were tactile and

interesting objects for people to engage with.

Staff and people living in the home were all positive about the changes both to the environment and to the service delivered. We were told the food had much improved and there was a choice. Staff told us they felt better supported by each other and the new manager.

People living in the home were treated with dignity and respect and we received quotes showing that people appreciated the support provided to them.

The provider and registered manager had introduced a live action planning tool which was updated regularly. We noted that concerns identified by the commission were mostly known of by the provider and were on the action plan. Staff could influence meetings and suggest ideas for improvements which helped them feel part of a developing and improving team.

The overall rating for this service is 'Requires improvement'

You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

We saw safeguarding procedures were in place but incidents were not reported as they should be.

The home had recruited enough competent care staff but there was not enough clinical oversight of the nursing home.

Individual risk assessments were not completed as they should be and risk management plans were not developed.

Medication was administered safely and in a person-centred way. Primary records were held and were accurate. However, PRN protocols and other monitoring records needed improvement

We could see records of when things had gone wrong. Information was shared with staff and changes made as required but not all concerns were addressed in this way.

The home was clean and domestic staff told us they had everything they needed to maintain the cleanliness in the home.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

The service took steps to gather the latest best practice information and sourced up to date and relevant training as required. Staff felt supported but evidence of regular formal supervision and appraisal was missing.

We saw people were weighed regularly and expert advice was sought when required to support people at risk of malnutrition.

The building was in a period of transition with the complete refurbishment of the home planned. Equipment and furnishings were also being updated. The provider had further plans to deliver a more personal service through the adaptation of the building

We saw work had been done to assess people's capacity but there was further work required to ensure the service was delivered within the principles of the Mental Capacity Act 2005.

We saw consent was acquired from people who had capacity to give them.

## Is the service caring?

**Good**

The service was caring.

We saw staff had good knowledge of people and understood how to ease their anxiety

People and their families felt involved with how their care and support was delivered.

People living in the home were treated kindly and respect was shown towards people by the staff.

People told us they had choices in their daily routine and that things had much improved in the last 12 months.

## Is the service responsive?

**Requires Improvement**

The service was not responsive.

Records were not developed to include person centred care. We found when care needs changed reviews did not take place in a timely way and support provided was not in accordance to people's care plans.

We saw limited activities taking place. People told us there was not much to do. There was evidence to show this would improve.

The home had a complaints policy and procedure but it was not used effectively to monitor complaints made.

There was no one living in the home on end of life at the time of the inspection. We did not see any evidence to show this had been considered when planning people's care

## Is the service well-led?

**Requires Improvement**

The service was not always well led

The new provider had taken steps to improve the ethos and values base of the staff team and it was clear this was having a positive impact on the care and support delivered.

The staff team felt involved in the planned improvements at the home and senior staff told us they could influence change and its implementation.

The home was required to develop a stable management team structure with appropriate clinical oversight.

There was a comprehensive suite of quality audits and monitoring and the provider was aware of changes in legislation and best practice. They took steps to introduce it to the home as required.

# Asmall Hall

**Detailed findings**

## Background to this inspection

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

We completed this inspection on the 4, 5, 6 and 9 July 2018. The first day of the inspection was unannounced

The service was inspected by two adult social care inspectors 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. In this instance the expert had experience of supporting people living with dementia.

Prior to the inspection we reviewed all the information the commission held about the home and contacted local key stakeholders including the Clinical Commissioning Group and Local Authority to gather their views on the service. We used all the information we gathered to develop a plan for the inspection.

The provider had not submitted a Provider Information Return as one had not been requested. This is information we require providers to send us at least once annually 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 11 people who lived in the home and seven visitors, we also spoke with one visiting professional.

We spoke with 14 staff including the registered manager, home manager, clinical lead, domestic and catering staff as well as nurses and carers.

We reviewed seven people's care plans in detail and looked in five others for specific information. We looked at records for monitoring people's health care needs including positioning charts and food and fluid intake charts. We also looked at the records kept for the administration of medicines and the recruitment of staff.

We looked at management information including the personnel files of six staff, details of audit and monitoring information to keep the service safe and feedback received from people using the service and their families.

We looked around the whole building including the communal bathrooms, lounges and quiet rooms and looked in people's bedroom accommodation, the kitchen and laundry.

We completed 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.

Requires Improvement

# Is the service safe?

## Our findings

When we asked people if they felt safe, we got mixed responses. Mostly people told us the building had good security into the units and they felt safe from intruders. However, when we spoke about the time it took for their support needs to be met, people told us they sometimes had to wait and this made them feel at risk. One person told us, "If I have to wait for someone to support me to the toilet I'm tempted to try and get there myself and I know I should not do this as I'm at risk of falling."

We saw a falls risk assessment which identified one person was a risk of falls and bedrails were in situ to reduce this risk. Another assessment identified the bedrails as a risk as the person attempted to climb over them. No further action was taken to address this risk and meet the needs of the person. The assessments had not been reviewed in the three months prior to the inspection. The person's general risk assessment had been completed in July 2018 and identified a risk as the person would not wear their lap belt whilst in the wheel chair. The risk management plan was to encourage to wear lap belt. This did not address and manage the risks. The bedrails risk assessment had not been reviewed since April 2018 and clearly identified the bedrails as a risk yet they were still being used.

We looked at accident and incident records and saw the home had developed a falls prevention monthly review document. This document detailed the people who had fallen that month and the circumstances of that fall. We noted that in the month of May it took between six and 27 days to review the persons falls risk assessment following a fall. This did not give staff the information they needed to reduce the risk of further falls. We also noted that most of the key documents to assess and manage the risk to people's health and wellbeing did not always identify the risks and when it did the risk management section of the document was not completed. This meant that the home was not taking all reasonable steps to reduce risks to people. We found the lack of risk management extended to all areas of risks including diet, continence and use of equipment.

We found the provider had not taken appropriate steps to manage risks to people in the home and staff were not given the support to reduce those risks. The lack of risk assessment and appropriate risk management is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We discussed the staff structure in the home at length with the registered manager and other senior staff. We were provided with rotas for two weeks. We found the rotas did not show consistent hours from day to day or night to night. They also showed many shifts that were still required to be covered. When we spoke with staff about the numbers and delegation of staff, we were told that things had improved since the last provider and that they were aware more staff were being recruited to fill any vacancies. We saw agency staff were used to cover the rota.

We went on to look at the availability and suitability of staff to support people in the home. When we spoke to people living in the home about staff we were told by all but one, that there was not enough staff. Everybody we spoke with told us the staff were all lovely but there was not enough of them.

We discussed the availability and role of nurses with both a range of different staff grades and found the home did not have clinical oversight or clinical supervision built into the structure. The registered manager was developing the structure and by the end of the inspection was aware more needed to be done to ensure clinical tasks were delegated safely to seniors if this was to continue. We found there were enough staff on duty but the role and delegation of the staff required more thought. There were not enough nurses employed at the home to safely manage the clinical governance required for nursing homes. This included the planning and delivery of clinical care. We were told nurses had been recruited but then either had not turned up or had only worked a couple of shifts. We were also told shortly after the inspection that the clinical lead had also left. We found the provider had not recruited enough competent and skilled staff to meet the needs of the people living in the home and found them in breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Senior care staff administered medication after they had been assessed as competent by the clinical lead. We observed two medicine rounds and found staff were respectful to people and delivered them in a person-centred way. We saw records used to administer and record medicines were accurate and up to date. We did note some concerns re the cleanliness of the clinic room and staff didn't wash their hands prior to administering medication or wear gloves. The registered manager assured us information had been shared with staff of our concerns and it would be addressed moving forward.

We had concerns around the administration of as required medicines and found protocols for the administration of these medicines needed further development. This was specifically in relation to what they were to be used for and how staff would gauge the need for the medication when the person was unable to verbalise this.

Creams and liquids from bottles and tubes should be dated when opened. This ensures staff were aware of the date to dispose of them as most are to be disposed of after so many days from opening. We found records of when these were opened were not consistent. We also found records of fridge temperatures were inconsistent. The provider assured us this would be addressed immediately after the inspection. The registered manager emailed us following the inspection to say all medicine concerns had been discussed with senior staff and nurses and that a fridge was being purchased in line with good practice that recorded the minimum and maximum temperature of the fridge in any 24-hour period. We have recommended medicine protocols and practice are revisited to ensure they follow best practice guidelines.

The home kept good records of incidents of safeguarding and reported them to the Local Authority safeguarding team when deemed necessary. Staff we spoke with had a good understanding of safeguarding and told us they would report anything they were concerned about. There were posters displayed around the home of when to report and details of the Local Authority safeguarding team. We found the CQC had not received a notification unless the incident had been reported to the safeguarding team under the new guidance. We asked the provider to review the statutory notification guidance and ensure all notifications were sent to CQC irrespective of the referral to the safeguarding team we were assured this would happen moving forward.

When issues or concerns were identified by professionals we found the provider was quick to remedy any concerns. This included the fire department recent visit and request for outside steps to be painted yellow. This was completed immediately upon request.

There had been a number of recent incidents upon which the provider had reflected. Staff were beginning to complete reflective practice documents and forms were being developed to introduce new processes and guidance following incidents as part of a lessons learnt methodology. We could see this was still in its

infancy but were assured this would become standard practice moving forward.

Equipment used to keep people safe and systems and equipment used to keep the building safe and secure, were monitored as required, including the professional testing of equipment used for fire safety and lifting equipment.

There was a developed contingency plan for use in the event of an emergency. This included specific personal emergency evacuation plans for people living in the home.

Recruitment information was mostly held electronically with all paper files being downloaded onto the home's computer system or in the process of being downloaded. We saw potential staff completed an application form and were interviewed. Following a successful interview, the required safety checks were undertaken to ensure staff were suitable to work with vulnerable adults. This included submission of references and checks made with the disclosure and barring service. Once checks were completed staff were offered contracts and these were signed. We found the recruitment process was equitable and fair.

The home was in the process of refurbishment. Most of the building work had been completed or was in the process of being completed following an initial deep clean and refresh of decoration. The home was clean and without odour. We saw monitoring was completed by domestic staff of the cleanliness of the home and cleaning schedules were used to ensure all areas of the home were kept clean and tidy.

There was a clinical waste contract and clinical waste was managed appropriately all staff told us they had access to available equipment to keep them and people in the home safe from risk of infection.

Requires Improvement

# Is the service effective?

## Our findings

We asked people what they thought of the food and generally received a positive response. People told us there was a choice and the food was well cooked. The people who were less pleased were those with special diets or with support needs associated with eating their meals. We looked at the available support at the lunch time setting and saw some people were struggling to eat their meals with the equipment provided. We were also told that one person had to be careful as sometimes their food was not given to them at the correct consistency.

The provider had recently introduced a Dementia Mealtime Assessment Tool (DMAT) The tool was used by staff to assess what additional support was required to enable people to remain as independent as possible when eating and drinking. However, we did not see any of the evaluation and monitoring of the care plans to ascertain the success of the tool. Staff did not appear to support people differently at the mealtime service based on the results of the DMAT.

We checked the available information in the kitchen to ensure the chef had the correct information available for people's diets and did see some inconsistencies in the information they held and that in people's care plans. We also saw people were not supported as was referenced in their care plan. We saw one person who was supposed to be supervised when eating being given a banana and a bag of crisps in their room and the staff member then left to continue the medication round. We saw, and it was reported, in the kitchen and in one person's bedroom, that one person with diet controlled diabetes was to be given tea with three sugars, liked marmalade and sweet things. It was acknowledged that this may be the case but the care plan stated staff should encourage a better diet. There was confusion as to how this person should be supported. The provider had sought support from a local GP who had stipulated to allow the person to continue to have three sugars in their tea. We recommended the provider ensures that appropriate documentation is made available to support staff in best supporting people in the home and in line with their assessed needs

We saw that people were weighed regularly and people were remaining at steady weights. When people did lose weight, we saw referrals were made for professional support and increased monitoring was undertaken to record what people were eating and drinking.

We saw staff asked for consent from people before interventions and we saw formal consent had been acquired for the delivery of care and support. Consent had also been acquired for photographs and the administration of medication.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 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.

Records were kept of people's capacity and assessments were completed based on specific decisions. Deprivation of liberty safeguards had been applied for and these were monitored monthly to review if anything had changed and to reaffirm the need for approval with the Local Authority.

When applications had been approved and restrictions had been applied, we saw when circumstances changed the Local Authority were asked to review the decision based on the individual's circumstances.

Records we reviewed showed a mixed understanding of the MCA. We saw one assessment which identified the person as having capacity to make a specific decision. Because staff did not feel they were making a wise decision they deemed he could not have understood the risks. As a consequence, they went on to make a best interest decision. Best interest decisions are only made when people lack the capacity to make decisions themselves and this was not the case in this situation. We saw assessments for medication to be given covertly that had not been signed off by the person's power of attorney. Further assessments were required in some cases and others required more thought. We recommend the current assessments are reviewed and where further work is required it is undertaken.

We spoke with staff about the induction they received to their role and the support they received once in employment. We were told of a comprehensive induction and probationary period. Staff felt confident within the probationary period and that they could access additional support without fear of reprisal. Clinical staff told us they met to discuss clinical issues and supported each other well. We were told all staff administering medicines had been signed off as competent and staff told us they had been observed undertaking the role. However, we did not see this quality in the records held. Both supervision, clinical competence and appraisal records for staff were limited. Some were out of date and others were not signed off. We recommend the provider takes further steps to formalise these important support procedures across the staff team.

Time had been taken time to research best practice for the client group supported. This included innovation work completed by researchers across the world. Local and national guidelines had been acquired and were displayed in the home and given to staff. These were then discussed in team meetings and if required additional training was provided. The provider used a range of training techniques including classroom, electronic learning and video. We saw how the provider had developed questionnaires for staff to complete as part of post course evaluation to ensure the learning had been understood and could be implemented within the home.

The provider used the most up to date technology and had created online forums for staff to engage in general peer review and support but also to share good practice and remind staff of key events and available training and meetings.

Staff at the home had recently received training in Equality, Diversity and human rights and we saw the beginnings of workstreams for both staff, people in the home and relatives to gain an understanding of people's protected characteristics and what people should expect. One staff member had begun to develop a piece of work around sexuality and a timeline of the understanding and acceptance of people's sexuality and sexual orientation was being developed. This would be used to raise awareness and importantly open lines of communication.

Staff told us they received excellent training and we saw from the available certificates and personnel files that this had improved greatly in the last 12 months. We reviewed the provider's policy on training and found it did not reflect the level and quality of training provided. The training coordinator was to revisit this and ensure it reflected the training provided.

Champion roles had been given to certain staff in their areas of interest including safeguarding, dignity, falls and nutrition. Staff received additional training in these areas and shared best practice with the rest of the staff team.

Referrals were made to external support organisations as required including the mental health team, falls team and district nurse team. People told us when they felt unwell, staff acted to address concerns.

We spoke with a visiting professional who told us things had improved since the new provider had taken over. They felt staff knew people living in the home well and were available to support them when undertaking reviews. We were told there were still some things that needed to improve including risk assessment and care planning but the home was moving in the right direction. The assessor concluded by saying, "I used to worry about people when I left after visiting here, I don't now so that shows a great improvement."

The building is currently being refurbished and has improved considerably in the last 12 months. It was clear the design of the building is being adapted to the people supported including the design and layout of the dementia unit which was in line with best practice guidelines. There was good signage around the home and it was clear which areas had been completed. They contained good reference to orientation including, clocks, calendars and seasonal references. The space had been designed to allow for quiet space if required and for socialising.

Good

# Is the service caring?

## Our findings

Staff at the home took their time in supporting people and worked with them to support their independence where this was possible. Advocacy services were used to support individuals who had no family involvement. We saw positive interactions between staff and people in the home including an awareness of their likes and dislikes. One person had a likeness for bananas and we saw staff had one to hand in the event they became anxious. This worked as a distraction as the person became focused on how they were going to eat the banana. For example, if they were going to hold it once half peeled, wanted it sliced in a bowl to eat with their fingers etc.

Another person had a varied and interesting past working in foreign countries alongside ambassadors. This person was beginning to find it difficult to vocalise but it was clear they wanted to tell each new person they met about their life. The home had supported the person to develop a book in photos of their past and they sat with it keen to show people who showed an interest.

We saw pictures were used to communicate with some people in the home and were assured this was to be introduced with other people in the home, as new staff got to know people better.

When we spoke with people in the home and their families about how they were treated we received positive comments including one family member, who told us how they made the choice to place their loved one at the home, "When I first came to look at the home, no one knew I was coming and the home was calm and people were laughing, that spoke volumes for me." Another visitor told us, "All the staff and nurses are really caring, I can come and visit when I want and take [family member] out when I want, I am always made to feel welcome."

People living in the home told us, "All the staff are marvellous, you can ask them anything." Another said, "The staff are excellent, I've no problems, they are always bright and cheerful and we have a bit of banter." Another person said, "The staff are very nice, there are very good and very polite. If you treat them right, they treat you right. I can't fault the staff."

Visitors told us they were asked about the care their loved ones needed when they first moved in and were kept up to date with any changes. We were told they were kept informed if there were any accidents or incidents that effected their loved ones.

People told us they were asked what they liked to do, what they liked to eat and even how they liked to take their medicine. We saw the medicine round involved a mixture of drinks, including, water, lemonade and orange juice.

We were told that people could feedback to the home how they thought their loved ones were cared for and there was a suggestion box and a recognition box. This was used if they thought a carer had gone above and beyond. One person told us, this was a good idea because the staff don't get thanked enough for what they do.

People's care plans had begun to be updated with their preferences and we saw night care plans which told us how people liked to sleep and if they wanted to be checked on through the night.

We observed staff asking people if they wanted to join in activities or where they would like to sit to eat their meal or have a hot drink. We saw staff knocked on people doors before entering their rooms and people were supported to their rooms for privacy when being supported with their personal care needs.

We asked people about how their belongings were looked after and the laundry of their clothes. People told us they often end up with someone else's clothes. We could not discuss this with anyone as when we visited the laundry there was no one there. We reviewed the systems in place to manage people's laundry and saw each room had a dedicated box and hanging space. We were assured a staff member was on site delivering laundry to people's rooms.

We checked that people who were assessed as requiring glasses permanently were wearing them and saw they were, we also saw the optician visited people as required. This ensured people were appropriately supported with their vision.

People were well presented and clean shaven if this was their daily routine. The hairdressing salon was open weekly and people told us they enjoyed visiting it.

Requires Improvement

# Is the service responsive?

## Our findings

At the time of the inspection the provider was managing Asmall hall as their first nursing home. The care plans being used were originally developed for residential settings. The provider was in the process of developing clinical assessments and care plans to fit in with the initial paperwork. There was not a consistent quality in the records held. We discussed this with the registered manager and the clinical lead who acknowledged staff were being trained in their completion. The clinical lead showed us hand written care plans which were person centred. Both the registered manager and the clinical lead acknowledged there was more work to do on developing the clinical assessments and care plans.

We looked at seven care plans in detail, pathway tracking people's needs assessments, care plans and associated risks.

Each file we looked at included a care plan summary. But we found these did not always reflect the information within the care plans. For example, one person's care plan summary stated the person could eat what they wanted yet their care plan identified intolerances to certain foods. It was acknowledged there was some uncertainty with the assessment, but clearly said if this type of food was to be eaten, refer to the GP and complete a capacity assessment from which a best interest decision should be made. This had not happened.

At the front of each person's care file was a list of sections which were ticked if reviewed and had been updated. We noted in one person's care plan review that this person had put on nearly 20Kgs in weight in approximately four months and it was recorded that the care plan had been changed in April 2018. But this was not the case and the care plan and nutritional assessment still showed them as high risk. The assessment also reported that the person required full support with eating and drinking, food should be cut up and should drink from a beaker with a spout. We observed this person eating independently at the lunch time service without any difficulty.

We spoke to the wife of another person living in the home who told us their partner had developed some difficulty swallowing. They had been eating their meal in their bedroom. They were aware of risks associated with this and had discussed them with staff. The family member told us the person was to be bought down into the dining room for meals moving forward so staff could determine if professional support was required. We looked at this person's care plan and assessment for nutrition and swallowing and found a risk assessment had not been completed and there was not any record of staff encouraging them to come to the dining room or for their swallowing to be monitored. This left the person at risk of choking.

We were told another person had recently stopped using a catheter. We looked at this person's care file and none of the associated care plans or assessments had been updated. This included their night time care plan, waterlow assessment and daily living assessment. This meant staff did not have up to date information on how to support this individual.

We looked at the care plan of one person who had fallen in May 2018 and hit the back of their head. This

person's falls risk assessment had been re written at the end of June 2018. The risk assessment stated the person had one or more fall 3-6 months ago. There was no record of the fall in May, no change to their care plan and no increased risk noted following the fall. This left the person at risk of harm.

During observations of a medicines round we noted one person's pressure mattress was set as if the person was 52Kg in weight. This person was mostly in bed and the pressure mattress setting needs to correctly reflect their weight to reduce the risk of pressure sores from immobility. We looked in this person's care plan and saw that their last weight in May 2018 was recorded as 40.1kgs. This meant the mattress was not correctly set and could increase the risk of this person developing pressure sores.

Due to some people's health care needs they had problems managing emotions and this could result in certain behaviours that staff found difficult to manage. We saw records used to monitor people's behaviour that were good accounts of what happened and the triggers that led to any incidents. We saw the provider had begun to use the disability distress assessment tool which identified people's presentation when calm and when distressed. This allowed staff to ascertain from someone's mannerisms if they were in a calm or distressed state. However, this form tended to be completed after an incident and the information from it was not then used to develop risk management plans and support mechanisms for suitable distraction.

We spoke with staff about how different people presented and it was clear they were aware of many of the early warning signs to distress for the people they were supporting. We also saw good distraction techniques used over the four days we were on site. This was not being captured and recorded in the person's care plan.

We could see there was a system in place for care plans to be reviewed monthly. We saw this did not always happen and some of the care plans we looked at had not been reviewed for up to three months. This was the case even when people's circumstances and health care needs had changed.

When assessments are not completed appropriately or are inaccurate, there is a risk appropriate support will not be provided. When care plans do not include details of how to support people with specific care needs and associated risks their care and treatment will not meet their needs. There was not any evidence in the above people's files that any further assessment had been completed which involved the individual or the individual's representative in addressing their changing needs. This is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2018.

Staff and the people living in the home and their families had begun to develop life stories. These mostly included pictures of specific events in people's life's. Others were in text and identified what was important to the individual including family, faith, hobbies and interests.

We spoke with agency staff including an agency nurse who told us they received a high-level document identifying the key needs and areas of risk for each person living in the home. Including the person's dietary needs and medical conditions and any equipment used. We were told they didn't receive this under the previous provider and it gave them confidence to do their job.

We saw different tools being used to engage with people who could not verbally communicate including a picture board and use of an ipad to communicate.

Over the course of the inspection we saw limited activities taking place. We saw one game of large dominoes and building with bricks and people reading newspapers and magazines as well as word search and crosswords. Other people were either sat looking out of windows or watching television. We were told by the

manager one activity coordinator had called in sick at the time of the inspection. We asked seven people who lived in the home directly how they spent their days. All of them told us there was not much to do. Most told us they liked reading and watching the birds, two told us they would like to use the garden more and another told us, "I watch television, there's not much else to do." A visitor told us, "There's supposed to be activities, but I've not seen anything."

We did not see anybody engaging in any meaningful activity around daily living. We discussed this with the registered manager who assured us that once all the personal history documents were collated and developed, more activity coordinators were to be employed to specifically move this activity area forward.

There were photographs displayed around the home, in albums and people's care plans showing involvement in activities both within the home and in the community. Annual celebrations including birthdays, Easter and Christmas events were also included. Each year the home had a summer fair in the gardens and they were in the process of planning this years at the time of the inspection. We recommend the provider develops and shares more comprehensive detail of the activities available to everyone living in the home to ensure people are aware of what is available.

However, we did see good evidence that people were involved in activities. There were photographs displayed around the home, in albums and people's care plans showing involvement in activities both within the home and in the community. Annual celebrations including birthdays, Easter and Christmas events were also included. Each year the home had a summer fair in the gardens and they were in the process of planning this years at the time of the inspection. We recommend the provider develops and shares more comprehensive detail of the activities available to everyone living in the home to ensure people are aware of what is available.

The provider had a complaints procedure which was available to people in the home in their service user packs and displayed on notice boards. There were no recorded complaints in the complaints file yet we were told of three formal complaints that had been made in the 12 months prior to the inspection. We were told of two that had been investigated formally by the clinical lead and the family had been happy with the response.

People we spoke with told us when they raised concerns they were dealt with promptly. Others who had not raised concerns told us, they felt they would be dealt with if they did. We recommend the provider captures complaints formally to ensure a record is kept of the action taken.

At the time of the inspection there was no one in the home at end of life. We saw information in paperwork at the home of someone who had previously passed away in the home. They had wished for their spouse to be with them in the last weeks of their life. The home had arranged this and people in the home had moved rooms to make it possible. The couple were supported in a double room until one passed. This was a good example of people's preferred priorities for care at the end of their life being followed.

We saw many people had DNACPRs in place. When we looked at these we saw most were indefinite decisions yet this decision had not been signed off by the clinician. This is required for these very important documents to be implemented.

The care plans we looked in did not contain any formal record of preferred priorities of care or advanced care planning. We did not see an end of life care plan in the master file documents for use at the end of someone's life. We recommend the provider reviews all the home's end of life care planning, assessments and procedures to ensure they can practically be implemented when someone passes or is at end of life.

We saw many letters and cards giving compliments to the staff at the care and support they provided family members

Staff told us about how things had improved specifically for some of the most vulnerable people in the home. One told us, "[Resident] didn't used to hardly eat or drink, it was like they had given up, they are much brighter now and are eating well." We were told by another staff member about one person who had become socially isolated. "[person] would just stay in their room, no one had time to try and coax them out, [resident] now comes down to the lounge and joins in activities." They told us, "That's why I'm in the job, for the residents."

We spoke with one visitor whose parent had recently come to the home. It was their first experience of residential care. They told us, "I think this is the best care [family member] can have, I think this is the best care home [resident] could be in." Their family member had specific needs and had recently been diagnosed with dementia and had sensory health care needs. We were told that the routine needed to make their family member remain calm and feel secure was followed.

Requires Improvement

# Is the service well-led?

## Our findings

Benridge Care Homes Limited took over Asmall Hall following the last inspection at which the service was rated as inadequate overall. The new provider had invested a considerable amount of money into the service redesign and decoration of both the interior and exterior of the property. In addition, investment had been made to the staff team with an emphasis on additional training for staff to be able to undertake their role both effectively and consistently.

Due to the large overhaul of the service the embedding of new systems and procedures had taken time and was ongoing. This being the first nursing home in the provider group had led to delays in understanding the structure required in managing a nursing home supporting people with both general nursing and dementia nursing needs. The large footprint the home covered also required thought for staff delegation.

The provider had resources for addressing and meeting the requirements of the regulations and many of these were in folders and to be introduced. The primary aim at the time of the inspection was to recruit and induct a structure and management team who could take forward the changes and monitor implementation. it was evident from the information reviewed as part of the inspection that the clinical team at the home required further oversight. At the time of the inspection the provider had a clinical lead in post and a care manager but the clinical lead was also the nurse in charge on the floor. Whilst doing this there was no time to complete clinical audit of issues and incidents or develop clinical supervision. The provider has had difficulty in recruiting to the clinical posts. Since the inspection the clinical lead has also left the service. We recommend the provider develops a stable management structure with appropriate clinical oversight as required for nursing homes.

There was a registered manager in post who was also the registered manager for two other services. This was discussed in detail.  At the time of registration the registered manager informed the Commission this situation would change. During email dialogue with the Commission the registered manager has said all services in the provider portfolio would have their own registered manager and they would become the area manager. We recommend registered managers are recruited to each location as soon as practically possible.

The current registered manager was a family member of the newly appointed nominated individual so there was not any distanced objective oversight of the home. We were told an external consultant was due to complete an audit but it had not yet been completed.

We saw the results of resident surveys completed since the provider took over. Questions included the cleanliness of the home, the quality of the food, respect and privacy provided and staff skills. Results were predominantly positive. The home had not had a resident meeting but had not had a relatives meeting in 12 months. The minutes of the only meeting held, identified the journey the new provider was to take, to drive improvements to the home's environment and service provided. We asked seven people who lived in the home if they knew who the manager was and five of them did not. We recommend the provider begins to hold resident and relative forums so the views of this group can be regularly gathered and actioned to

ensure the service is in line with the expectations of the people living in the home.

Every staff member we spoke with praised the rest of the staff team and how they all worked together as part of a bigger team. We were told of the improvements made by the new provider and how much the culture at the home had changed. Staff felt they were on a journey of improvement and felt involved and could take ownership of the changes required to drive that improvement. Each felt supported by their peers and direct manager including the new registered manager and clinical lead. One staff member told us, "With the management in place the door is always open if I need help I get it, before I felt like I was just left to get on with it." Another told us, "I understand why decisions are made and am involved with both making them and changing practice. I'm much happier, everyone is much happier now."

All staff had received an induction into the ethos, values and procedures of Benridge Care homes.

We saw meetings were held to discuss the development and management of the home. The minutes of each meeting included an action plan and a responsible person was identified to drive the action forward. Meeting minutes with action plans were placed into an action plan folder which was reviewed by the registered manager and actions were signed off once completed. The provider also held more informal meetings with staff around coffee which were recorded. These discussed potential areas of concern that the staff wanted to be discussed more formally within team meetings. We saw the agenda items of future team meetings reflected the items raised by staff in these forums.

Staff received an employee handbook which they signed as read and understood. The handbook included the ethos and values of the service and key policies for staff including confidentiality and receiving gifts. Staff told us they found the handbook informative. One senior member of staff told us," it feels like the home has moved a million miles since Benridge took over."

The provider had a developed a service user guide which included key information about the services provided at the home and the contractual obligations of both the provider and the person living in the home. The guide included lines of communication with the provider and the provider's complaints policy.

The provider had signed up to national best practice websites and took steps to ensure any changes in law or best practice were introduced. This included additional work undertaken at the start of the year when new laws came into force to protect the personal data of individuals. The provider had completed the kings fund enhancing a healing environment audit tool and had worked towards it when developing the interiors of the dementia unit.

Where new guidance and policies were released the registered manager took these to the staff team meetings for discussion and ideas on how best to implement

The provider had a comprehensive suite of quality audits and we could see from these that many of the concerns noted by the inspection team had been identified by the provider. Staff had been allocated as champions in specific areas and they were responsible for completing audits in that area. The audit was then reviewed by the manager and the action plan developed including any required training. An annual action plan was seen which was a live document and was added to as the registered manager reviewed the completed audits and saw further improvements they wanted to introduce or where the timeliness of change had not been met. Action plans were developed from meetings, audits and monitoring undertaken. The provider was also working through policies and new best practice guidance as they were introduced and developing action plans to be implemented

There was monthly analysis undertaken of the monitoring and submission of records including accidents, medication, training and infection control. Where required the registered manager completed investigations and root cause analysis of incidents to reduce risks moving forward. Each month the management team introduced the policy of the month, the topic of the month and audit of the month. The topic of the month primarily focused around the regulations of the Health and Social Care Act.

A recognition box was in the main foyer for staff and family members to deposit nominations for staff who had followed good practice or gone that extra mile. Everyone we spoke with, we asked what they liked best about the job. One staff member simply told us, "Being thanked for what I do." We were told the job can be quite challenging and a simply thank you at the end of the day helped so much with morale.

The provider was part of local forums working with other providers to share best practice and learn from issues and incidents.

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<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>We found assessments and care plans were not developed with the involvement of the person or their representative. When people's needs changed the appropriate assessment and care plan did not always reflect this. Care plans were not developed to provide staff with the information they needed to meet people's needs. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks identified were not correctly assessed and risk management plans were not developed to reduce or mitigate the risk. Where risks were identified the information from assessments was not effectively used to produce associated risk management plans<br><br>There were not enough suitably skilled and qualified staff to meet the needs of people in the home. The home lacked clinical oversight. The delegation of clinical staff did not allow them to plan effective care and treatment |