Care Quality Commission

Barchester Healthcare Homes Limited

Stamford Bridge Beaumont

Inspection report

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Date of inspection visit:
30 August 2017
11 September 2017
15 September 2017

Date of publication:
14 November 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 30 August, 11 and 15 September 2017 and was unannounced. Stamford Bridge Beaumont is a care home with nursing for up to 107 older people, some of whom were living with dementia. There were 76 people living at the service at the time of the inspection.

The service was meeting all regulations at our last inspection in November 2016. We had made two recommendations about responding to concerns and other issues, and the rating for that inspection was requires improvement. At this inspection we found breaches of Regulation 9 Person centred care, Regulation 10 Dignity and Respect, Regulation 11 Need for consent, Regulation 12 Safe care and treatment, Regulation 13 Safeguarding service users from abuse and improper treatment, Regulation 14 Meeting hydration and nutritional needs, Regulation 17 Good Governance and Regulation 18 Staffing. 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.

There was a registered manager employed by 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. Following the inspection we were told that the registered manager had left the service.

We found multiple failings at the service and risks to people had not been mitigated. People were not cared for appropriately. 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 who were at risk of dehydration and malnutrition did not always receive the level of support they needed to ensure good health. In addition positional changes for people were not carried out according to the instructions in people's care plans putting them at risk of skin damage.

Staff were recruited safely but there were insufficient numbers of staff on duty to meet people's needs effectively. There was a heavy reliance on agency staff who did not always know people well which put them at risk.

Some people had behaviours that challenged staff and staff were not trained appropriately. Training was not up to date and staff had not been adequately supported through supervision.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. 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.

Medicines were not managed well in every area of the service. We saw poor practice by one staff when administering medicines. A community pharmacist informed us of their concerns about medicines management which included poor record keeping and missed doses of medicines.

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 some staff. However, other staff did not always promote people's dignity or meet people's basic care needs through the care they provided.

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

Activities were not meaningful to people living with dementia. There were no stimulating activities for people during the inspection and very few items available to stimulate people, such as books or magazines to look at.

The service had some characteristics of a dementia friendly environment but did not always reflect current good practice guidance.

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

People knew how to make a complaint but we saw that where complaints had been made they had not always dealt with in line with company policy.

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 now being addressed by the registered provider but there were still significant 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 provider 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 not safeguarded because staff had not followed correct procedures to report incidents.

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

Medicines were not managed safely across the service.

Is the service effective?

Inadequate

The service was not effective.

Training was not up to date and staff practice demonstrated a lack of knowledge and understanding. Staff supervisions had been carried out but had been used for training rather then the support and development of staff.

People's nutritional and hydration needs were not always met and staff practice when people required support to eat and drink did not follow good practice guidelines.

The service had characteristics of a dementia friendly environment but improvements were required in order to meet the needs of this client group.

Is the service caring?

Requires Improvement

The service was not caring.

We saw variations in the care provided to those people who were living with dementia. People's dignity was not supported through the care they received.

Support for people's personal hygiene and appearance had not been managed well by staff in all cases.

Feedback about staff was positive and people described them as, "caring." Although we saw some positive interactions between staff and people who used the service we also saw examples of staff having a lack of awareness and being uncaring.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans did not always reflect the care people received.

Activities were not meaningful and were not provided every day.

People knew how to make complaints. Some people were not always satisfied that complaints had been looked at in sufficient detail.

Is the service well-led?

Inadequate

The service was not well led.

There was a registered manager employed but they left the service after day two of the inspection. The lack of effective leadership was 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 and the local authority regarding safeguarding matters.

Care Quality Commission

Stamford Bridge Beaumont

Detailed findings

Background to this inspection

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

This inspection took place on 30 August 2017, 11 and 15 September 2017 and was unannounced. Prior to the inspection we had received a concern from a whistle-blower which prompted our inspection to be brought forward. Day two was completed between 8.30pm and 1.30 am and day three started at 6am. These out of hour's visits were in response to further concerns we had received and our observations on day one of the inspection. We discussed all of these concerns with partner agencies including the local authority safeguarding and quality monitoring teams and the police.

The inspection team on day one was made up of four adult social care inspectors, a bank inspector and two experts by experience with experience of older people and dementia. The team on day two were two adult social care inspectors and an inspection manager and on day three there were three adult social care inspectors, one specialist nurse advisor and two experts by experience with experience of older people and dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed notifications we had received from the provider. 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. The provider had previously completed a Provider Information Return (PIR) in June 2016. 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. We had not asked for another PIR to be completed by the provider.

During the inspection we spoke with fifteen people who used the service, six relatives, two unit managers, four nurses, two senior practitioners, seven care workers, the activities co-ordinator and two kitchen assistants. We also spoke with the chief operating officer, the regulations manager, the quality manager, the regional manager and the registered manager during the inspection. 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.

We looked at records including care plans, risk assessments, food and fluid charts, repositioning charts and medicine administration records for nineteen people who used the service. We also looked at five staff recruitment records, training records and training matrix, rotas and other documentation relating to the running of the service such as quality audits.

We observed lunchtime in each unit and medicine administration in three units. When we started our inspection at 6am on the 15 September 2017 because concerns had been raised about people being dressed and put back to bed, we checked every bedroom as soon as we arrived.

During and following the inspection we contacted ERYC safeguarding and quality monitoring teams for feedback and to update them about our findings where we had concerns for people's safety. We highlighted concerns to the North Yorkshire Fire and Rescue service and the infection control nurse. We contacted an advanced nurse practitioner for feedback and spoke with a community pharmacist.

Inadequate

Is the service safe?

Our findings

Prior to this inspection we received information from a whistle-blower about a serious safeguarding incident at the service. The information about this incident had not been shared with the East Riding of Yorkshire council (ERYC) or CQC by the provider. ERYC have responsibility for investigating any matters relating to safeguarding adults in this area and the provider has a legal responsibility to notify CQC of any safeguarding incidents. This matter was referred to Humberside Police because of the nature of the concerns and is currently under investigation.

In addition, three people had raised concerns with us about the care of their relatives. All of this information raised potential concerns about how people's care was managed at this service. The information we received identified there may be issues in the following areas: inadequate pressure area care, people not given enough to drink, people not safeguarded, documentation not being completed correctly, staffing levels not adequate and deployment of staff not safe and concerns regarding the leadership of the service. We looked at these issues during the inspection and found evidence to support these concerns and additional areas of concern around people's care and safety. We made four safeguarding alerts to ERYC following the inspection.

People and their relatives had mixed views about staff numbers. One relative told us, "I left around seven o'clock wondering how many staff would be looking after the residents, and my (relative), overnight, and how I am the only person who appears to be concerned." Another person told us, "They get agency staff which I was concerned about, but they are not left alone." We found that this was not the case.

One of the three days of inspection was out of normal working hours because we understood from information we received that there may be a lack of staff which affected people's care during the evening and at night. We found that staffing was not adequate to meet people's needs during the day or at night. Staffing was particularly low on one unit for people living with dementia during the evening and at night.

There was one person working on one of the dementia units alone at night caring for fourteen people. Twelve of those people required two staff to provide their care or supervision. This meant that the care worker had to ask for assistance from another unit for those people leaving another unit short of staff and putting people at risk. On the same unit we were told and rotas confirmed that on three days in the week one nurse finished work in the late afternoon and they were not replaced leaving only two care workers on that unit. When we spoke with one staff they told us, "We can manage with two but really need three staff. It impacts on staff as they don't get breaks and miss lunch to make sure people get the care they need." We saw that on eleven days out of seventeen in August 2017 there had been only two staff working on this unit after 430pm.

When we arrived for our early morning inspection we found that there were 12 staff on night duty and nine of them were agency staff. Every nurse on duty was an agency nurse and one had not worked at the service before so was not familiar with people's needs. One agency nurse told us that there was no-one receiving end of life care on the unit where they were working. This was incorrect showing a lack of knowledge about

people's needs. On another unit a care worker told us that the nurse had gone to assist elsewhere. When we went to find them they were not on that unit. The care worker was alone with people that required nursing care and had no clear knowledge of where the nurse was. This meant that people's safety had not been properly considered because there were insufficient staff on those units and staff were not always aware of people's needs. This was confirmed by one person who told us, "They are using a lot of agency staff and you have to tell them what I need and it gets very tiring having to repeat myself."

According to the needs assessment tool used to determine staffing levels the number of staff had been sufficient which we had seen was not the case. We saw examples where the assessment tool was incorrectly completed. In addition, staffing was worked out across the whole service and not by individual units which did not always reflect the level of need in those areas. This meant that in some areas staffing was dangerously low and in the event of an emergency staff would not be able to evacuate those people. Following feedback on days one and two of the inspection we saw on day three that additional staff had been brought in to the service by the provider.

We made a recommendation at the last inspection that the registered provider should take action to ensure that sufficient numbers of staff are consistently deployed in order to meet people's needs promptly. This had not happened.

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

During the inspection people told us they felt safe living at the service. One person said, "I feel very safe living here" and another said, "There is enough staff, I am well looked after." A third person said, "I am safe I have access to my buzzer [call bell]." When asked if their relative was kept safe a visitor said, "Yes."

Appropriate safeguarding policies were in place for the service. These policies were in place to ensure the correct management of any allegations of abuse. However, we had been told by a whistle-blower of several allegations of abuse that they and five of their colleagues had witnessed. The staff had reported verbally, in writing and had given the manager witness statements in relation to these allegations. None of the allegations had been reported to ERYC or CQC.

The manager had conducted an internal investigation without following the correct local area or company procedure. They had concluded that most of the allegations had related to moving people and arranged for the member of staff to be retrained. In fact, these were serious allegations which are now been investigated by the police. All staff, including the manager, had received training in safeguarding adults during the last year in line with company policy. This meant that some people were not safeguarded at this service because the manager had not recognised the seriousness of the concern or alerted the appropriate authorities with details of the incidents.

All of the staff we spoke with demonstrated detailed knowledge on the practice and principles of safeguarding. This included how to recognise and act on different signs of abuse and neglect. In addition staff had recently undertaken additional training that helped them to understand safeguarding in the context of other cultures.

Although staff said they were happy with the safeguarding training provided, they did not feel well equipped to support patients who were aggressive or violent. Staff did not have breakaway or self-defence training, which meant they were not trained to protect people who were violent or themselves while trying to support people. One care worker said, "We do have people who can be violent but we don't get told how to handle

this. We get to know them so can develop techniques to calm them down but not how to defend ourselves and protect [the person] from harm at the same time." We found staff had experienced situations in which they were placed at physical risk without appropriate training. For example, one person had thrown chairs and a table at staff and on another occasion a care worker had physically intervened when two people had started fighting each other.

We also observed practice in regards to behaviour management which was unsafe and disrespectful.

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

Barchester Healthcare Homes Limited is part of the Primary Authority Scheme (PAS Scheme) which means they have a designated fire service that deal with fire safety in all their properties. This is Lancashire Fire and Rescue Service (LF&RS). They held a copy of the fire risk assessment for the service which was also in held at the service.

All of the staff we spoke with demonstrated knowledge of fire safety and evacuation procedures. This included individual areas of responsibility and the use of the emergency grab bag at reception. An evacuation ski pad was available on the first floor landing in one stairwell. This equipment enables trained staff to safely and quickly evacuate people with reduced mobility using a vertical route in an emergency. There was not a ski pad on the second floor, which meant people living on that floor had no means of being safely moved if they had low or no mobility. In addition a fire extinguisher on the first floor landing had been serviced in January 2017 but the pressure gauge indicated the extinguisher was out of the safe range to be effective.

We saw that 47 per cent of staff had taken part in fire drills. We asked if these numbers included agency staff and were told that they did not. 75% of night staff working on the 14 September were agency staff and over half of people who used the service required two people to assist them which meant that people could not be evacuated safely. Agency staff would be unaware of the evacuation procedure for this service. Humberside fire service had visited the service on 14 February 2017 and had identified that, "All staff should take part in scenario based physical evacuation drills." People were put in danger because the provider had not carried out these drills for everyone. We informed Humberside fire service of our concerns and they arranged to carry out a visit to the service.

We had noted that a large number of fire doors were open as we walked around the premises. The fire officer told us the doors were on free swing devices which are designed to close on fire alarm activation and at all other times are designed to hold their position at any point on their travel which means they may appear to stick if you try to close them. The doors were operating as they should but staff were not aware that this was how they worked.

The registered provider had a medication policy. Nurses, senior practitioners and senior care workers administered medicines on each unit. People told us that they got their medicines on time and received pain relief when required. Comments included, "Every day I get my medicines on time," "Sometimes it's late at night" and "I do get pain relief."

We observed medicines being administered and looked at a selection of medication administration records (MARs) on the Circle, The Terrace and the Old Manor units. We found that on the whole medicines were managed safely on the Circle and The Terrace units. When we had observed medicines being administered in the Old Manor unit we saw a senior care worker take four people's medicines from the trolley in separate

pots stacked on top of each other. When we asked why they were doing this they told us that they knew everyone and knew who had which tablets. This increased the chance of errors being made and was not good practice.

Since the inspection we have spoken with a community pharmacist who told us that they had visited The Lodge, The Terrace and the residential unit following the inspection and conducted independent audits of the medicines practice on those units. They told us that medicine administration records in the Lodge were incomplete. There were missed signatures on these records and in some cases people had not received their medicines. They knew this because the stock balance was more than it should be. In one case a person had four tablets more than they should and so missed four doses of medicine. In the Lodge the pharmacist had also found that fridge temperatures had been higher than the recommended limits for storing medicines and had been for a period of time. Temperatures had been recorded by staff but no action taken.

In addition, they found that one person in the residential unit had not received an injection prescribed every twelve weeks since 31 May. The injection was a lifelong treatment for a particular condition and the person should have received it in August 2017 which meant they were at risk of symptoms re-occurring. The pharmacist told us they had contacted the ERYC safeguarding team about these matters.

There were protocols in place for people who were prescribed medication for use 'when required'; these protocols did not give clear instruction to staff about why the person may require this medication. Records were completed when people received these medicines.

Some people were prescribed controlled drugs (CDs). CD's are medicines which require stricter legal controls to be applied to prevent them: being misused, being obtained illegally or causing harm. We had inspected the CD book and random stocks on The Circle and The residential unit and found them to be correct. However, the community pharmacist told us they had reviewed the CDs on The Lodge and found that the medicines had been incorrectly recorded in the CD book and no audits of the CDs had been completed by staff.

This showed us that systems and practices were not in place for the safe management of medicines and people did not always receive their medicines safely.

The registered provider completed risk assessments in relation to people's needs. These included assessments in relation to falls, moving and handling, skin integrity, continence and food and fluid needs. The Malnutrition Universal Screening Tool (MUST) was used to assess people's risk in relation to malnutrition. Risk assessments were reviewed monthly. However, staff did not always follow the guidance within the risk assessments in order to maintain people's wellbeing. For example, one person was identified as at risk of low intake of fluid so had been placed on a fluid chart. However, on three days out of four their fluid intake was recorded between 250mls and 550mls of fluid per day. Another person received only 70mls of fluid between 6am and 3pm. They were left drinks but did not touch them and no-one offered support. This meant that people were at high risk of dehydration but staff had not put measures in place to ensure they had regular drinks. The provider was not doing all they could to mitigate risks to people's health.

When we looked around the service we observed several areas where there was a risk of infection because appropriate measures were not in place. For example, one bathroom in The Lodge had no soap or paper towels for people to use to wash their hands. There were remains of food on the floor in The Croft and there was an unpleasant smell in the middle of the corridor which was also evident in the rooms in that area. We were unable to establish what was causing the smell. We reported our concerns to the community infection prevention and control nurse specialist who visited the service.

They told us, "There were a few domestic cleanliness issues, but overall the standard of environmental cleanliness was good." However they went on to describe other factors which posed a risk of infection such as, most pressure relieving cushions dirty with staining on inner surface, surfaces on some upholstered chairs, worn/damaged making effective cleaning difficult and exposing inner foam to risk of contamination. Some wheelchairs were dirty. Wheelchairs, hoists and walking frames were not on an equipment cleaning schedule for regular cleaning or additional cleaning whenever visibly soiled or after use. In addition medical devices were dirty and equipment left on the floor posing a risk of contamination.

We saw that records of any accidents or incidents were completed by staff and reviewed by the manager to make sure appropriate action had been taken in response to any incidents. The manager recorded information about accidents and incident's on the registered provider's electronic clinical governance system, so that data could be analysed in order to identity patterns and action required. There had been 103 accidents listed as unwitnessed falls with no injury between 1 January 2017 and 31 August 2017.

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

Servicing and maintenance checks of the premises had been completed in house and by external contractors in a timely manner. These were recorded. 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.

The registered provider also had a business continuity plan detailing how they would ensure people's safety and comfort in the event of an emergency, such as a fire or flood.

The registered provider had a safe system for the recruitment of staff. We looked at recruitment records for five staff. Appropriate checks had been completed before staff started work. The registered provider had completed Disclosure and Barring Service (DBS) checks. DBS checks provide information about any convictions, cautions, warnings or reprimands. They help employers make safer recruitment decisions and are designed to prevent unsuitable people from working with adults or children who may be vulnerable. Nurse's qualifications had been checked with the Nursing and Midwifery council (NMC).

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 we spoke with told us they thought staff were well trained. One person said, "The carers are fantastic. I came in on a stretcher and look at me now. I can move around and walk. I am so lucky to be here." One member of staff said, "We just help people do things they can no longer do for themselves. It's very rewarding." A second member of staff told us they could not remember having an induction and said, "I have had no refresher training just mandatory training and the care certificate."

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 training relating to dementia and challenging behaviours and no regular competency checks which meant that training was not embedded. In addition, there had been a lack of support for staff. One member of staff told us, "The carers care about people and try to do their best, nurses are fantastic but it is exhausting at the moment." A care worker said, "I have had no one to ones or supervision." Staff did not always feel supported.

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 that staff had started to follow the principles of the MCA Code of Practice 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.

Although staff were able to tell us about best interest decisions that had been made we could see that decisions about people's care and treatment had been made internally and did not always have any input from 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 relevant 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. In addition there was a lack of understanding around the role of next of kin. One

person had instructions from their next of kin taped to the front of their care record telling staff they should not be admitted to hospital but there were no supporting documents to say they had lasting power of attorney or that a best interest's decision had been made. The term Next of Kin (NoK) was commonly used and there was a presumption that the person identified as NoK has certain rights and duties. This may not be the case.

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. Neither a GP nor a pharmacist had been involved in the decision making.

People's consent was not always sought before providing personal care. We saw one person being coerced by staff into having a bath with staff using restrictive holds of their arms in order to transfer them into a wheelchair and into the bath. The person was saying they did not wish to get in the wheelchair or go for a bath but were not listened to by staff. Their care plan said, "Staff may need to use gentle holds for personal care" but there was no formal record of a best interests decision being made and therefore the restraint should not have been carried out.

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 the local authority. Records confirmed these had been applied for and the decisions had been made in the person's best interests.

Where appropriate, Do Not Attempt Cardio Pulmonary Resuscitation consent forms (DNACPR) were correctly completed with the relevant signatures.

People who could communicate their wishes were asked in some units where they would like to eat their meal. This could be in the dining room, in the lounge or in their bedrooms. In other units the meal was served to people where they sat. Menus were displayed but on the ground floor the previous day's menus were displayed. The dining room tables had table cloths and cutlery settings. The food looked appetising and there were several choices of menu. People told us, "Food not bad but not a lot of choice" and, "Cannot fault the food; it is excellent." Staff supported people where necessary to eat and drink. Some people were given finger foods which were helpful in encouraging people with dementia to enjoy their food. As dementia progresses people often find cutlery difficult to manage.

We saw that drinks and liquid supplements were offered during the day however; people were not routinely supported to drink sufficient fluids. We saw that one person had a drink on their table but had not touched it all morning. Staff did not encourage them to have a drink. Other people had drinks in their rooms but these were out of reach. Food and fluid charts were in place for some people but the recording of fluid intake was poor with charts not completed. People were not always receiving adequate fluids. One person's care plan said that fluids should be encouraged had received only 460mls of fluid all day and another person had only had 70mls of fluid at 2.50pm which was not adequate. The Association of UK Dieticians recommends that women drink an average of 1600mls of fluid a day and men 2000mls.

We found fluid chart entries were not always '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. In addition, we saw that there was no record of fluids being given to some people after 530 pm. Five fluid charts in The Croft had recorded entries after 7.35pm but when we checked later that night staff had entered amounts retrospectively so we could not be sure those people had received any fluids.

In addition people's nutritional needs were not always met. One person's care plan said they should have 'soft chewable foods' as they had few teeth with which to chew food. The care plan also stated they required adapted cutlery as they lacked dexterity. We saw they had been given a breakfast which included bacon and sausage. In addition they were given ordinary cutlery. This meal remained untouched. Staff eventually changed this for a snack plate which also remained untouched as did the lunch provided. None of the staff took time to support this person with eating and drinking.

One person had a change in their weight and their care plan stated they should have a four day food and fluid chart in place but this had not been put in place and so it was difficult to monitor accurately what this person was eating and drinking. Another person's care plan stated soft diet was needed. However, the speech and language therapy team (SALT) had recommended a pureed diet. The care records were confusing for staff and it was not clear which diet this person should receive.

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

Following the inspection the provider assured us of their intention to review each person's needs in relation to nutrition and hydration.

There were snacks available in the communal areas which contained fruit, crisps and biscuits that people could eat throughout the day. However, in some areas people were not able to access the snacks freely and were reliant on staff assisting them. We did not see staff giving people snacks in those areas.

The environment had been adapted to support the needs of people living with dementia but the layout of different areas was confusing. The personalisation of bedroom doors could have been improved. The bedroom doors all looked the same and there was the outline of old bedroom numbers on the doors and then small paper signs giving new numbers. There were no customised signs to identify the person's room using names and photographs or personal objects. The signs were difficult to read and this was not helpful for people in retaining independence in finding their own way to their room.

There was very little signage to promote people's independence in moving around the service. We did see a picture of a bath on bathroom doors. Disorientation and bewilderment are a common experience for people with dementia. There were also some displays in communal areas to prompt conversation and reminiscence.

The service was well lit and contrasting colours had been used in order to highlight important areas such as bathrooms. There were pictures on the walls which can help people living with dementia communicate.

Training for staff was available in all areas the registered provider considered mandatory but there were gaps where some staff had not completed this training. The training included areas such as health and safety and moving and handling and was provided through eLearning and some face to face contact with trainers. Since the inspection the company trainer is now spending time at Stamford Bridge Beaumont to ensure staff are supported in their training. Staff had received minimal training in dementia care and no

form of nonphysical intervention training. This training was crucial as the service provided dementia care and some people who used the service had behaviours that challenged staff. We did not see any competency checks completed by senior staff which would have enabled theoretical training to become embedded in staff practice.

New care workers were mentored in their role for the first two weeks. Staff had received supervision but it was not sufficient to supporting them in their work. The supervisions focused on one subject and a short discussion and were very brief. We saw one supervision record which had covered the subject of mealtime experience but there was no review of actions from the previous meeting and the action plan was that staff follow procedure. The supervision record did not identify what knowledge or skills the care worker had or where additional learning or development was necessary. Staff had completed an appraisal by answering questions and marking themselves and this process was repeated by the appraiser. Staff then completed a plan of training for the following year. There was no record of discussions or any personal development opportunities recorded. We discussed this with the manager who agreed they were not adequate.

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

Conditions which required monitoring were managed in consultation with the advanced nurse practitioner who visited the service twice a week. They were also a nurse prescriber. This meant that once the diagnosis had been established by the GP the nurse prescriber can monitor the condition and prescribe for that condition in agreement with the patient. We spoke with the advanced nurse practitioner following the inspection who was able to confirm some details for us about people's care. Staff supported people to attend hospital appointments.

A 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. In addition there was a ten minute stand up meeting where the senior staff from each unit met to discuss staffing needs, daily tasks and make arrangements for someone to accompany people to appointments. GP and other health care professionals visits were recorded which meant that communications around people's health were easy to monitor. However, the advanced nurse practitioner told us that, "Sometimes I am not told about serious issues." They said that all staff had direct access to them via telephone.

Requires Improvement

Is the service caring?

Our findings

One person who used the service described staff as "A very caring lot." A second person said, "Yes (staff were caring). If there is anything wrong I tell them and they sit down and talk about it and that's what I like." A third person said, "The carers are lovely. I can talk to them."

Relatives told us that staff were kind. They said, "Staff are fantastic. They are amazing both for him and for me." A second relative told us they had been included in discussions about their relatives care and said that they [relative] had been supported to be as independent as possible.

Staff demonstrated kindness, compassion and good humour to people and their relatives in some areas of the service. For example, several members of staff checked a person sitting alone in the Terrace lounge during the course of a morning. Each member of staff had their own rapport with the person, who was demonstrably pleased they were being looked after. Administration staff made friendly conversation and care staff offered to sit and read the newspaper with the person.

However, this level of compassion was not practiced throughout the home. For example, we asked a care worker why one person was spending more time in their bedroom rather than socialising, which they liked to do. They told us this was due to a condition which was, "Unsightly to other people who lived there" and so staff encouraged the person to stay out of communal areas.

A care worker sat in a lounge having a drink while people were asleep on chairs and sofas. One person was asleep face down on the arm of a sofa still wearing their glasses. Although the care worker was sitting in close proximity, they did not demonstrate appropriate awareness of the needs of those around them.

We saw that one person had long dirty nails and several people were seen to have food or drink spilled on their clothing. One person was left in clothing that was wet with food and drink during the morning. Some people were having their hair done by a hairdresser but we saw that other people's hair had not been brushed all day. When people had eaten, particularly finger foods, staff made no attempt to assist them to wash their hands. In addition, 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. When we explored this with staff they were unable to confirm when these people had been fully bathed.

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.

One person had demonstrated behaviour that challenged staff during the night and was left sleeping on the sofa in the communal lounge all morning. When they did transfer to their bedroom they were laid on a bed which had no sheets.

During our night visit we observed several people asleep in chairs, one with their meal in front of them and another who had been incontinent. We also heard one person shouting "No" and "get out" which staff

ignored.

A visitor told us that people walked in and out of other bedrooms and took people's photographs and other personal items. Apart from when tasks were being completed there was very little interaction between staff and people who used the service.

The staff had not supported people's wellbeing or promoted people's dignity.

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

We observed one person been assisted by staff to complete an exercise regime. Staff spoke kindly to them and encouraged them throughout the exercises. One relative told us, "[Relatives] clothes and hair reflect their normal preferences."

Some people had an independent mental capacity advocate (IMCA) and others had access to advocacy which could be arranged by the manager if required.

On the whole, people who received end of life care at the service had been identified in their care records. Where appropriate there was an advanced care plan in place and anticipatory or 'just in case medicines' were in place. One person had their preferred place of care identified. People's care was overseen by the advanced nurse practitioner. However, in one case we saw that records stated one person had been seen by their GP and that they may be approaching the end of their life. Staff had not updated the person's care plan to reflect this and no anticipatory medicines had been prescribed. In addition, no clear communication had taken place with the family.

Requires Improvement

Is the service responsive?

Our findings

Care planning documentation did not always reflect the care that was being provided to people and people did not always receive care that reflected their preferences. The files were well kept and the care plans were appropriate to people's needs in most instances. When risks had been identified there was a good association between risk and planned support which is good practice. However, observed practice did not always reflect this. One person had been readmitted to the service following a hospital admission but their care plan had not been fully updated to reflect their care needs. Most care plans had been evaluated monthly and some reviews of people's care had been completed by health and social care professionals.

One person's care plan identified that they required a particular diet and equipment but neither had been provided. We saw that other people required regular repositioning and the frequency was highlighted. However, when we checked their charts we saw that these frequencies had not been adhered to and people's tissue viability was compromised because staff did not follow clear instructions. This combined with a lack of fluids meant that people were at higher risk of skin damage. Dehydration creates delays in all aspects of wound healing.

It was not always evident that people's individual needs could be met at night when staffing was lower. For example on one day of the inspection a care worker found two people in their clothes in bed. Their supper was still in the fridge despite food charts indicating they had eaten these items. The care worker challenged their colleagues who said that the people had 'fought with staff' when they tried to assist with personal care and so people had been left in their clothes. On a second day we found that three people had been dressed and put back to bed early in the morning. The care worker we spoke with could give no reason for this and said, "I have always been expected to do this since I came." This suggested that this was a cultural issue with staff following an existing pattern of behaviour. These practices were task orientated and did not reflect person centred care.

We did not see any planned activities during the days of inspection. There was an activities co-ordinator and two activities assistants employed at the service. We spoke with one of them. They told us that, "A lot more could be done There is nothing to assist carers with people who are living with dementia."

In one unit we observed four people playing a game with a care worker. One person told us, "I like to go to church and I like to watch football on the TV. Sometimes my family take me to a football match." People told us they looked forward to seeing the activities assistants. We saw that activities were advertised and there was a list of things people could do each day.

However, there were no activities that were meaningful to people living with dementia. Although each person had a communication plan which helped staff to understand how to interact with them there was no evidence this was being used to support people appropriately. Activities for people living with dementia do not need to be structured or complicated. The best ways of helping the person with dementia to remain active and stimulated are to keep him or her involved in the day-to-day tasks in and around the home. We did not see this happening and so people were not engaged with staff and either slept for long periods or

displayed behaviours that challenged.

We did not see any one to one interactions take place. People nursed in bed were socially isolated and only visited when they required care to be provided. 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.

One relative told us, "They [staff] are going to start including [Relative]" and another said, "My relative enjoys the music sessions downstairs. Hopefully we will be able to get back into that."

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

People knew how to raise concerns or complaints. They told us they would speak with a member of staff or the manager. One person said, "I did have a problem and spoke to a nurse. They told me they would sort it out and they did. I have had no problems since." A relative told us, "I made a complaint and it was dealt with straight away." However, other people had told us that they were not satisfied that complaints were investigated thoroughly and had raised concerns with CQC prior to the inspection. There was a lack of management oversight of complaints and we saw no evidence that complaints had been analysed to identify reoccurring themes where learning could have taken place and improvements made.

Inadequate

Is the service well-led?

Our findings

Stamford Bridge Beaumont is one of 183 services run by Barchester Healthcare Homes Limited. There was a registered manager employed at this service. We were told following the inspection that they had left the service. At the time of our inspection they had been registered at the service approximately 3 months. From 1 November 2016 until 31 January 2017 the manager had a period of acting up into the role. The registration process commenced in January 2017, the application was accepted and in place from 6 June 2017. We saw they had not received adequate support during their induction and as such leadership was inadequate. The provider identified this themselves and introduced additional management support to the service during the inspection.

The manager had a team of specialists from whom they could draw expertise, such as quality specialists and dementia specialists. Within the service they were supported by unit managers. 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 or until further staff were recruited but were often strangers to people in the service which could have an impact on people's safety and quality of care.

Safeguarding alerts had not always been made to the local authority or notified to CQC but the service was now working with the local authority and other professionals to make improvements in this area.

The registered provider put a voluntary embargo on admissions to the service which has now been formalised by CQC and the local authority.

There was a quality assurance system in place but a lot of the issues we raised during the inspection had not been identified in audits completed by the service. For example, managers had not monitored the standard of care that people had been receiving effectively. In addition people who displayed behaviours that challenged staff had been identified but no action had been taken to put the correct support in place for them. The levels of staff required to provide safe care and support had not been identified appropriately using the providers own tool. This meant that the audits and oversight of the service was not robust. This had resulted in a situation where the basic care of people 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 in August 2017 but none had been recorded in the central log. This meant that the registered provider could not be aware of all of the incidents which had taken place within the service or be sure that action had been taken to reduce the risk of similar 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 were at risk of pressure ulcers their plan of care had not always been followed robustly and where people were advised to have specific amounts of fluids

this had not been provided. This meant that people were at risk of harm.

Records were not kept up to date. For example we saw that care plans had not always been updated following changes in people's needs. In addition it was unclear whether people had received food or fluid as the records had not been completed after 5.30pm – 630pm.

There had been a lack of effective leadership and management oversight at the service by both the manager and provider. Risks had not been mitigated and people were not cared for appropriately. 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 Barchester company website says about the assistance people will receive, "Our assistance is consistently top quality and person-centred." 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, "I have had concerns over the last few months about how the service is run. It has not been a nice place. "

Some relatives and staff did not feel confident raising concerns with senior management for fear of how they or their loved ones would be treated by the service. We also noted that when staff raised concerns and witness statements had been taken, management had advised staff not to talk to anyone about their concerns as it would result in dismissal. In addition not all incidents had been notified to CQC although this was been rectified by the management team. This had not created an open, honest and transparent culture within the service.

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 staffing and managers spent time at the service effecting change. 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.