

## Barchester Healthcare Homes Limited

# Stamford Bridge Beaumont

### Inspection report

Buttercrambe Road  
Stamford Bridge  
York  
North Yorkshire  
YO41 1AJ

Tel: 01759371418  
Website: [www.barchester.com](http://www.barchester.com)

Date of inspection visit:  
03 September 2018  
04 September 2018

Date of publication:  
04 October 2018

### Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Requires Improvement ●

# Summary of findings

## Overall summary

The inspection took place on 3 and 4 September 2018. This inspection was unannounced on the first date and announced on the second date to ensure the provider was available to discuss feedback.

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

The care home accommodates up to 107 people across five separate areas, during this inspection 55 people were living at the service.

A new registered manager had applied to register with the Care Quality Commission (CQC) since our last inspection and their application had been accepted on 3 August 2018. They had worked for Barchester Healthcare Homes Limited for eleven years, some of which were spent managing and overseeing other Barchester run homes in the East Riding of Yorkshire. The registered manager had previously supported Stamford Bridge Beaumont and they were knowledgeable in terms of the current issues, work underway and plans to maintain sustained improvements across 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.

At the last inspection in April 2018 we found the provider to be in breach of seven of the Health and Social Care Act 2008 (Regulated Activities) 2014 in Regulation 9 Person centred care, Regulation 10 Dignity and Respect, Regulation 11 Need for consent, Regulation 12 Safe care and treatment, Regulation 13 Safeguarding service users from abuse and improper treatment, Regulation 17 Good governance and Regulation 18 Staffing.

We also identified one breach of the Care Quality Commission Registration Regulations 2009. This related to the failure to notify us of other events and incidents which had occurred at the service as the law requires.

The service was rated Requires improvement. The provider continued to complete an action plan to show what they would do and by when to improve the key questions Safe to at least requires improvement.

We found during this inspection that the provider had made significant improvements, which achieved compliance to meet the requirements of Regulations 9, 10, 11, 12, 13, 17 and 18.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is

no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

At this inspection we rated the service Good. Although some areas of guidance and documentation needed embedding into day to day staff practice, overall there had been significant progress and improvement made throughout the service.

Management of medicines had improved since our last inspection. However, some areas of guidance and documentation required further attention. The impact to people was low as these were recording issues rather than errors in administration of medicines.

Quality assurance systems and audits identified where improvements needed to be made and noted good practice throughout the service so this could be communicated and celebrated with staff. However, some medicines audits required more detail to confirm which people's medicines had been checked.

Staff deployment across the service had taken staff experience and skill mix into account to meet the dependency levels of people living at the service. Although we did observe a couple of minor concerns, overall this area had greatly improved. In addition, only regular agency staff were being used and the amount had further reduced since our last inspection. The management team had been working hard to recruit the right staff in line with Barchester's values.

Group activities were regularly organised and a new activities co-ordinator was in place until further staff had been recruited. The activities team told us they were speaking with people to find out their likes and interests to ensure one to one activities and outings were more meaningful for people. Staff confirmed they were interacting with people as and when they had the time. We observed positive interactions between staff and people living at the service throughout the inspection.

Recording of one to one activities was inconsistent. Although they were more descriptive since our last inspection, some had only start times with no durations noted and for some people we were unable to see activity records being maintained. People and relatives had observed regular activities and interactions being completed by staff. This was a recording issue and the provider explained how they had focused on improving higher risk areas since our last inspection. The regional manager told us that although staff were getting better at recording one to one activities, this would be an area of focus for the management team to make further improvements.

Care plans had been reviewed since our last inspection. These were detailed and included information about people's health conditions and guidance for staff to deliver person centred care to people.

Risks to people had been identified and managed effectively. Guidance was clear for staff to follow and included signs to look out for in relation to risks associated to people's health conditions. Environmental risk assessments were in place and appropriate measures taken to mitigate identified risks to people.

People had been supported to have maximum choice and control of their lives. The principles of the Mental Capacity Act (MCA) 2005 were fully understood by staff and in most cases the MCA process had been followed and documented. We identified some areas where best interest decisions had been completed when there was no need and in some instances records did not show that relatives had been invited to have input in decisions made in people's best interests.

Safeguarding concerns had been documented and managed. The correct procedures had been followed by the registered manager, issues raised by staff had been reported to CQC and when necessary the local

authority.

Accidents and incidents had been recorded fully with actions taken to mitigate risks. These had been analysed and appropriate measures put in place to avoid reoccurrences.

People's nutritional needs had been assessed and measures put in place to support them. Food and fluid charts had been fully completed and totalled to ensure issues were highlighted and addressed immediately.

People and their relatives told us they were aware of the process to make a complaint and felt confident their concerns would be addressed appropriately. Staff morale had improved since our last inspection, the staff we spoke with told us they felt confident in the leadership at the home and would not hesitate to discuss their concerns with the management team or utilise the whistle blowing process.

A dementia specialist team had been working to support the service and ensure the environment was as dementia friendly as possible.

People told us they had ample choices of food and desserts, including regular homemade snacks and refreshments available throughout the day.

Servicing and maintenance of the environment including fire safety, servicing of utilities and equipment had been completed and certified by appropriately qualified professionals. Emergency evacuation procedures were available on each unit and at the reception area of the service. Contingency plans had been reviewed and updated to include current contact details for key stakeholders.

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

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

The management of medicines had improved considerably. We identified some areas that required further improvement, which the provider advised would be addressed immediately.

Deployment of staff across the service had improved. The use of agency staff had further reduced since our last inspection as the service had recruited additional permanent staff to maintain consistency.

Staff felt confident to raise their concerns with the management team and gave examples of issues already addressed by the new registered manager.

Risk assessments were in place for risks associated to people's specific health conditions and guidance for staff on how best to support them. Accidents and incidents had been identified and actions taken.

### Is the service effective?

Good ●

The service was effective.

Staff understood the importance of gaining people's consent and best interest decisions were in place. Although we found some areas for attention staff understood the importance of consent and best interest decisions were in place.

People's needs were assessed on admission to the service and documentation was clear and up to date to support staff to meet people's current needs. Staff encouraged people to eat and drink at regular intervals and encouraged people to maintain healthy diets where possible.

The provider had designed their induction to incorporate the care standards and values of the organisation. Staff received regular training and were offered additional courses to develop their skills and expertise. We found staff to be knowledgeable

about people's needs and how to best support them.

Supervisions and appraisals were completed at regular intervals in line with the providers policies. Staff told us they felt supported by the management team and although some supervisions were brief, others were developmental and encouraged reflective practice.

### **Is the service caring?**

The service was caring.

The management team spoke proudly about the staff team and how they had worked hard to achieve better outcomes for people.

Staff spoke passionately about their role at Barchester. Staff morale was high which had improved team working across the service. Staff had a proactive approach speaking with people and their relatives to capture diverse information to enable them to enrich people's lives and promote their well-being.

People and their relatives told us that staff always respected people's dignity and privacy. We observed meaningful interactions between staff and people throughout the inspection.

Staff were knowledgeable about people's needs and supported them wherever possible to be as independent as they could be. People told us that staff offered them choices and respected their wishes or preferences.

**Good** ●

### **Is the service responsive?**

The service was responsive.

Care plans were detailed and person-centred and tailored towards each individual's needs. They contained information about people's histories including their likes and preferences.

Group activities were regularly scheduled and a new activities co-ordinator had been working to improve one to one interactions for people who may be isolated due to mobility or cognitive impairment.

People and their relatives knew how to complain. Where complaints or concerns had been raised people told us they had been immediately addressed to their satisfaction.

**Good** ●

The provider had considered the Accessible Information Standards (AIS) to advise people they could request information in different formats to suit their needs if required.

### **Is the service well-led?**

The service was well-led.

We found some recording issues that required further attention. However, the impact to people was low and the management team took steps to address some of these issues during the inspection.

The provider had improved their quality assurance systems. Audits and quality assurance documents showed significant improvements had been implemented across the service. Accidents and incidents had been recorded in a timely manner and appropriate measures put in place to mitigate any risks to people.

The registered manager was knowledgeable about their responsibilities under the CQC registration requirements and had submitted notifications in line with CQC guidelines.

Staff told us the management team were extremely supportive and they felt confident issues were being addressed appropriately and openly. Staff enjoyed working at Stamford Bridge Beaumont and felt the changes made by management had impacted positively on the well-being of people living at the service. □

**Requires Improvement** ●

# 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 3 and 4 September 2018. This was unannounced on day one and we told the provider we would be visiting on day two. On day one the team was made up of three adult social care inspectors, one medicines team inspector and an expert-by-experience. Day two consisted of three 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. On this occasion the expert had knowledge and experience of caring for older people and those living with a dementia related condition.

We reviewed information we held about the service, such as notifications we had received from the provider and information from the local authorities that commissioned services with them. Notifications are when providers send us information about certain changes, events or incidents that occur within the service. The provider had submitted weekly action plans since the last inspection in April 2018 and was not asked to submit a Provider Information Return (PIR) before the inspection. 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 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 spoke with thirteen people who used the service, four relatives, two unit managers, a care practitioner, two nurses, three senior care workers, six care workers, one activities co-ordinator/administrator, one cook and a dementia specialist employed by Barchester Healthcare Homes Limited. We also spoke with the regional manager, the deputy manager and the registered manager.

We looked at records including care plans, risk assessments for eight people who used the service. We reviewed monitoring documents, such as food and fluid and repositioning charts. We also looked at five staff recruitment records, training records and training matrix and other documentation related to the

running of the service. We observed lunchtime in each area of the home and reviewed eight records relating to the management and administration of medicines.

# Is the service safe?

## Our findings

At the last inspection in April 2018 we had identified that the service was not safe. Safeguarding incidents had not been reported to external agencies. Staff felt unable to use the whistle blowing process to report concerns. Staff were using restraint without relevant training and against people's wishes. Accidents and incidents were not recorded in a timely manner or adequate action taken to prevent reoccurrences. Risk assessments were inconsistent and did not always contain detailed guidance for staff on how to support people. Medicines had not always been managed in line with the providers policy or administered as prescribed. Infection prevention and control issues had not been fully addressed in line with recommendations made by supporting professionals. Staff deployment during busy periods did not always consider people's dependency levels.

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

During this inspection we found that the provider had taken action and made significant improvements. We found these improvements achieved compliance to meet the requirements of Regulation 12, 13 and 18.

Systems were in place for the management of medicines so that people received their medicines safely. Arrangements were in place for recording the administration of oral medicines. We discussed with the registered manager how records and guidance for topical medicines and medicines prescribed 'when required' could be refined further. They agreed to improve records in this area and seek further guidance for topical preparations and review the documentation of medicines prescribed when required.

Although guidance for covert administration needed amending, decisions around using covert medicines were being managed better. Staff had spoken with the pharmacist about crushing one person's tablets and this has been approved for a person with capacity and appropriate care plans put in place. Staff told us they were contacting the GP about a second person with no capacity having a covert medicine plan.

A relative spoke highly about a member of staff, "I talked to [Name of staff] about medicine for [Name]. [Name] can't have [Name of a chemical compound] in their medicine as that makes them sleepy. Before I knew it [Name of staff] had contacted the nurse and a suitable medicine has been found." This demonstrated a positive approach of staff supporting people with their medication.

Staff deployment across the service had improved. The registered manager had considered staff experience, skills, layout of the building and people's dependency levels. Recruitment had still been an area of focus and the service had increased their permanent work with the current focus on recruiting nursing staff. Use of agency staff had decreased and was mainly used to cover some nurse duties and absences given at short notice. One member of staff told us staff gained experience working in different areas. They said, "This helps highlight how people work and sharing practices." We spoke with the registered manager regarding staff deployment." The registered manager told us this would continue to be an area they would monitor closely.

To support with allocation of staff a new call bell monitoring system was being put in place to ensure management had oversight.

Recruitment records showed the provider had systems in place to ensure checks were carried out before new staff commencing employment at the service. Records showed that Disclosure and Barring Service (DBS) checks had been completed to ensure people were of a suitable character to work in a care setting. Two references had been obtained for each member of staff and appropriate checks had been completed to ensure nurses were registered with the Nursing and Midwifery Council. To be registered nurses have to complete revalidation which means to continue practicing they have to meet certain requirements, which includes completion of specialist training. Agency staff had a profile provided by the employment agency, this recorded checks carried out and any training completed.

The management team had listened to staff and when necessary followed their disciplinary procedures. One member of staff advised, "I had to report a member of staff to management. They were being quite sharp with people and I didn't like it. This person has now been dismissed by management." This showed us that senior management were ensuring disciplinary processes were followed and any issues within the staff team were addressed appropriately.

Staff described how they supported people to remain safe. One member of staff advised, "Always know where people are and communicate with other staff. Follow care plans and make sure crash and sensor mats are on where needed. Deliver care as if it was my grandma or mum."

The registered manager was aware of their responsibilities to report abuse or allegations of abuse to CQC. The registered manager had completed safeguarding training delivered by the local authority. Concerns raised by staff had been documented and appropriate actions taken to ensure the safety of people living at the service. All safeguarding incidents had been recorded and managed by following correct procedures and making referrals to CQC and when necessary the local authority.

Staff told us they would not hesitate to use the whistle blowing procedures and felt their confidentiality would be maintained. One member of staff commented, "I would go straight to [Name of registered manager]. Much has improved, [registered manager] is approachable and does what she says she's going to do. People have a lot more confidence, I certainly do." Other staff told us they had spoken with the deputy and regional manager, that they had been understanding and supportive when they had spoken with them in confidence. One member of staff advised, "You never hear other people talking about your business anymore, the management team are professional."

Accidents and incidents records were recorded for each area of the service. Records were detailed and identified people, dates, times and a summary of the incidents. These were analysed monthly to identify any reoccurring themes. Quality and clinical governance meetings also identified any actions needed and appropriate measures had been put in place to mitigate risks to people. On occasions records did not always document when actions had been completed. For example, one person had been identified as high risk due to falls documented over a period of three months. This was highlighted during meetings and the clinical development nurse contacted. The care plan had been reviewed and updated to include information to guide staff in how to support the person to prevent falls. It detailed that the person may become agitated, shout out or try to stand up. Staff were guided to offer the person assistance to walk to the toilet when they made any of these gestures. Equipment such as; chair and bed sensory mats were put in place to alert staff should the person stand up to walk independently. Although the above actions had been taken, records did not reflect all the work staff had done. We had to find other documentation such as care plans to ensure appropriate actions had been completed. This is a recording issue which has been

addressed in the well-led section of this report.

Risks to people had been identified and managed effectively. Guidance was clear for staff to follow and included signs to look out for in relation to risks associated to people's health conditions. Environmental risk assessments were in place and appropriate measures taken to mitigate identified risks to people. For example, one person's risk assessment for outings stated they had poor hazard perception and no capacity to understand the risks posed by strangers. Staff were asked to ensure the person was wearing appropriate footwear and accompanied when they went out. A second person had asked for a valance sheet on their bed. Staff were asked to ensure it was positioned to avoid the person tripping and falling. Hourly observations had been put in place should the person be alone in their room. This showed us that risks were identified and managed in line with people's choices and preferences.

Servicing and maintenance of the environment including fire safety, servicing of utilities and equipment had been completed and certified by appropriately qualified professionals. Emergency evacuation procedures were available on each unit and at the reception area of the service. Fire alarms had been completed regularly and noted the time, date and staff that had attended. Contingency plans had been reviewed and updated to include current contact details for key stakeholders.

Health professionals had visited the service in August 2018 to follow up on previous issues. Although minor shortfalls were noted, feedback from the nurse included, "Everyone who has been involved in the achievements made should be very proud, as the report shows there has been a large improvement of Infection Control practices within the home."

During the inspection we observed the service was clean, tidy and free from odours. Risk assessments were in place for sensor mats and other equipment and included information for staff to follow. For example, mats to be washed when dirty, staff to complete visual checks for signs of wear and tear. Staff were seen to be wearing personal protective equipment such as gloves and aprons when delivering personal cares, administering medicines and carrying out domestic duties.

Care plans encouraged positive behaviour planning. For example, one person's care plan described how they expressed distress. They had been assessed as not having mental capacity to make their own decisions without support. Guidance was detailed for staff and provided examples of different distraction techniques that worked well for that person. We observed staff working with people to guide them when they were agitated, they remained calm and gently persevered to diffuse people's anxieties.

Guidance was in place to enable staff to support people as they had chosen in line with health professionals advice or best practice. However, the Cornell depression scale screening tool for depression in dementia had no clear purpose for its use. There was no information detailing what the scores meant. It was used to highlight whether a person was living in a state of well-being, but there was no evidence of how this was then used to improve their well-being. This was discussed with the provider for them to review.

## Is the service effective?

### Our findings

At the last inspection in April 2018 we had identified that the service was not consistently effective. Staff did not follow the principles of the mental capacity Act 2005 (MCA). Best interest decisions did not detail those involved. People's rights to make particular decisions had not been upheld and their freedom to make decisions had not been maximised, as in some cases unnecessary restrictions had been placed on them. Some staff practices and knowledge in relation to MCA was poor. Do Not Attempt Cardio Pulmonary Resuscitation consent forms (DNACPR) had not always been regularly reviewed.

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

During this inspection we found that the provider had taken actions and made significant improvements. We found these improvements achieved compliance to meet the requirements of Regulation 11.

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). The provider had schedules in place to ensure DoLS were applied for before their expiry dates. Records noted to consider whether a further application for a DoLS was required before requesting one. Where conditions had been stipulated the provider had guidance in place for staff to follow. One person spent a lot of time in their room and the provider had measures in place to ensure they had regular interactions with staff and opportunity for stimulus throughout the day.

The principles of the MCA were fully understood by staff we had spoken with. Although we did identify some inconsistencies in the use of the MCA. We found that mental capacity assessments and best interest decisions had not always been completed for sensor mats, crash mats or photography. Records did not always include relatives input. One family members had signed consent for people to have photographs taken; there was no evidence of a best interest decision taking place and no documentation to support that the relative had any lasting power of attorney (LPOA) in place. The purpose of LPOA is to meet the needs of those who lack capacity to look after their own personal, financial or business affairs. It authorises someone to act on your behalf in your best interests. This was an isolated case. Some care files had copies of relatives LPOA and others did not. The provider advised they had requested copies from relatives and the outstanding ones would be chased up to ensure they were in place.

Best interest decisions had been completed by the provider and recorded, but these were irrelevant for

some decisions. For example, best interest decisions had been completed for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and deprivation of liberty safeguards (DoLS). DNACPR decisions are assessed and signed by a GP and DoLS are authorised by the local authority after a full assessment by a GP or other qualified health professional to determine a person's capacity to make decisions for themselves. Where people lack capacity a best interest meeting is completed and family members invited to ensure people who know the person best have input into the decision-making process. We discussed this with the provider who took immediate measures during the inspection to review these areas.

New staff completed an induction which took a minimum of three months to complete depending on people's previous experience. Mentors were assigned to support staff during this period. The induction was tailored to include company values and cross-referenced the Care Certificate standards. A separate induction was in place for nursing staff which was tailored to their specific role. Competency checks were completed during induction, a mid-point and final review followed by a personal development plan.

The regional manager advised that staff received six supervisions per year, this included one annual appraisal. Reports for training deemed necessary by the provider showed overall 95.11% had been completed. This included supervisions at 92.31% and appraisals 93.42%. A variety of methods had been adopted to allow flexible working, these included; group and one to one supervisions and general chats when issues or concerns had been raised. We identified that the group supervisions contained more detail to support staff development and the provider advised they were considering using this format for future supervisions. Appraisals included self-evaluation of practice with aims and objectives set by the line manager. Where staff had requested additional training, future supervisions noted when these had been completed.

The operational training manager completed monthly observations of staff practices. These were recorded for specific duties including; moving and handling, person-centred approaches, fire safety, general health and safety and confidentiality. Actions and follow up were also documented and feedback given to staff during the daily morning meetings.

Staff told us they felt supported and all staff commented positively about the management team. Comments from staff included, "Definitely supportive of staff" and "100 percent supported by the manager and deputy. The manager is professional and very flexible. The regional manager is lovely."

A dementia specialist team had been working to support the service and ensure the environment was as dementia friendly as possible. We observed numerous improvements such as memory boxes in people's rooms or doors, additional signage throughout the home and noise levels had reduced. Scrabble letters had been used in some areas to spell out words of importance to people and memorabilia and pictures of things people liked were in various places throughout the home. The hairdressing salon had been completed and we observed people enjoying having their hair washed, cut and styled.

To promote continuity of care people had a named keyworker or nurse. When people transitioned through services, such as to hospital and then back to the home. Information was transferred with them so that people's needs were known to health professionals responsible for their health and well-being.

People's needs had been assessed and any recommendations put in place. For example, food and fluid charts detailed the recommended daily amount specific to each person as discussed with the GP or other health practitioners. All charts we reviewed for hourly observations, food and fluids and repositioning had been fully completed cross the service. We saw where people had not reached their recommended daily amount for fluid intake, this had been identified and guidance put in place for staff to follow. We observed

staff offering food and fluids to people at regular intervals throughout the day.

Records documented how staff worked well with health professionals to deliver effective outcomes for people. Staff had access to tools which supported them to assess and identify those people more at risk of developing pressure ulcers without preventative measures being put in place. Staff worked closely with the district nurses to ensure when marks or early lesions appeared they were treated to avoid any further deterioration. Symptoms for urinary tract infections had been identified in their early stages by staff that knew people well and could identify when people were presenting differently to what was normal for them. When necessary blood tests were arranged for dementia screening to diagnose conditions and ears checked to rule out infections or hearing problems. This showed us that staff had the skills and expertise to identify concerns early and seek the right treatment or guidance to maintain people's health and well-being.

People told us they had ample choices of food and desserts, including regular homemade snacks and refreshments available throughout the day. We observed that care was taken with presentation, such as pureed food being served in separate pots to look as appetising as possible for people. Specific requirements such as finger foods and fortified drinks were given in line with people's care planning requirements. One person refused to eat their lunch, staff were aware they preferred sweet choices. Staff offered them several options and the person chose to eat them all. This showed us that staff were considering alternatives to optimise people's nutrition.

We observed calm atmospheres in dining areas and staff offered people clothes protectors prior to serving lunches. Hot and cold choices were available to people and those that required assistance to eat and drink were supported at their own pace. Some people had chosen to move to other dining areas to eat and some people were served lunch in their rooms, these were suitably covered to prevent any contamination during transit. Staff interacted and conversed with people throughout mealtime.

Compliments received in relation to food and dining experiences included; "Lovely lunch- everything we tasted was good", "Smashing ploughman's lunch." Relatives had taken time to praise the efforts made by the cook and kitchen staff, "Just to say how much I appreciate all you do for [Name]. Your food is amazing but I love you all mostly because you go the extra mile" and "Thank you very much for the lovely anniversary cake. It made the day even more special."

The cook asked people to fill out forms to identify their likes and dislikes to devise menus that people would like. Staff inform the cook about any changes in dietary requirements and these were noted on a board in the kitchen for all staff to view. The cook was knowledgeable about people's dietary requirements and knew the consistencies of different pureed diets depending on the recommendations made by the SALT team. People that had allergies were clearly noted on the board. The cook told us how they fortified food to increase the nutritional content by adding cream and cheese into foods. Milkshakes were freshly prepared every morning and available all day. People requiring higher calorie diets had access to higher calorie snacks and mousses. Normal snack plates were available to accommodate people that did not need higher calorie content.

The cook advised, "We do nutrition week where we have to come up with new ideas for alternative foods for people to try as an activity. We have tried Pimm's with strawberries and cream. Ice cream trolleys when it's really hot, I enjoy this as I get time to interact with the residents." After lunch the cook walked around talking to people to gain their feedback about the food they had eaten.

# Is the service caring?

## Our findings

At the last inspection in April 2018 we found care plans lacked specific guidance for staff to consider people's behaviour to manage situations in a consistent and positive way to protect the people's dignity and rights. People had been moved to protect them from noise levels due to refurbishments, but one person's personal belongings had not been moved with them. One person was walking in and out of rooms with no staff present to intervene or redirect them. There was a lack of meaningful interactions between staff and people living at the service.

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

During this inspection we found that the provider had taken actions and made significant improvements. We found these improvements achieved compliance to meet the requirements of Regulation 10.

Relatives praised the staff for their caring and jovial approach when supporting people. One relative advised, "[Name] is caring and conscientious but most importantly her care of residents cannot be surpassed. If I hear [Name's] voice when I come in I am over the moon. [Name] constantly goes the extra mile if [Name] can do anything to make [Relative's name] life better and mine. I've always said you can pay people to do the job but you can't pay someone to care. I would have [Name] looking after [Relative's name] seven days a week if I could. I would give [Name] 11 out of 10."

Staff had created a pleasant and calm atmosphere throughout the service. Friendships had formed between people living at the service, at mealtimes we observed lots of laughing and smiling exchanged between people. On occasions we heard staff or people break into song, which showed us that people felt relaxed and happy.

The registered manager was encouraging staff to utilise outdoor spaces and encourage people to sit outdoors with their relatives to enjoy some quality time together. We observed people using outdoor seating areas to spend time with their relatives. This gave people some private space and had a positive effect on their well-being.

People living at the service told us they felt well cared for. One person said, "Staff are very kind. I don't need help but it's nice to know help is available if I need it." A second person advised, "Staff are lovely and so helpful."

Care plans detailed specific guidance for staff to manage situations in a consistent and positive way to protect people's dignity and rights. One person's care plan described their type of condition and presentation. The plan referred to others being moved away to preserve this person's dignity and detailed certain medicines to be given in privacy as this had been recognised as an invasive procedure.

We observed staff promoting people's dignity, knocking on bedroom doors before entering and asking

discreetly if they needed any personal assistance. One member of staff explained, "It's about preventing people from being viewed in situations they wouldn't want to be in. Knock on doors and cover people. If someone doesn't want something you don't force things on people." One person told us, "Staff ask me if I need support. Sometimes I say no, but if I need help, they help me. They use a bath chair to get me into the bath. Make sure I have all my soap, etc. They make my bed and come back, wash my back and help me out of the bath. They are very respectful of my dignity." This showed us that staff respected people's dignity and choices.

Records detailed the level of support people required from staff to maintain their mobility and personal hygiene. Care plans were in place for moving and handling which guided staff to encourage people's independence, especially when their abilities fluctuated daily. Staff knew the importance of encouraging people to be as independent as they could be to maintain their motor skills. One member of staff told us, "[Name] needs their food cutting up, I then give the fork to them rather than assisting them to eat – they will then eat without assistance. I know people's abilities and encourage them to be independent whenever I can."

Staff knew the importance of oral hygiene and were creative in finding different ways they could meet people's needs. One relative commented, "My spouse likes a daily shave and teeth cleaned. If [Name] don't want staff to use a toothbrush, staff will use a tooth sponge instead." Risk assessments had been completed in relation to the use and safety of sponge swabs.

We observed staff talking and interacting with people, referring to their past working life and involving them in conversations about the new school term and whose children were starting school for the first time. One member of staff brought their small child to visit people in the afternoon and people responded positively to these interactions.

Staff had taken time to communicate with people's relatives and spent time talking with people to build additional records about personal life histories. Information was communicated to people daily, such as activities and events that were happening in the service. Each person received their own activities plan and we observed people discussing between themselves and with staff to arrange which activities they would like to attend.

Care plans included cultural, spiritual and social values. One person's care plan stated to support to communicate and express himself and values to others within new relationships. However, there was no guidance for staff on how they should do this. Some people visited the local church and services were arranged within the service for people that wanted to attend them. One person's care plan stated they were unable to have pork due to their religious needs.

It was clear that staff involved relatives in their loved one's care and took time to talk with them. Records showed that relatives were invited and attended reviews every six months or when a person's needs changed significantly. Relatives told us that staff supported them as well as the people living at the service and this was evident during the inspection. Care plans encouraged staff to support people living at the service and their relatives. Staff knew the importance of building strong family relationships to support people and make them feel valued. Relatives said they felt comfortable visiting the service and no time restrictions were put on them. One relative told us, "Staff make me feel welcome, they offer me drinks and are very friendly and supportive." People looked happy and well presented. Staff told us that people seemed more settled.

Staff spoke to us about maintaining people's confidentiality and ensuring they did not discuss any personal

information with other people unless they were given authorisation to do so. People's personal information was stored securely in locked offices and computers had passwords to protect stored data. The service had updated their protocols to bring them in line with the new data protection laws.

Advocacy information was available for people and their relatives should they need it. One person told us, "Advocacy was explained to me. I set up [Name of relative] with Power of Attorney. I make all my own decisions. Staff like you to make your own decisions." This showed us that people had access to important information and that staff took the time to provide explanations to people.

## Is the service responsive?

### Our findings

At the last inspection in April 2018 we found some care plans were brief and task focused. They did not contain specific information to support staff to meet people's needs in a person-centred way. Information was inconsistent and not always aligned in relation to care plans and associated risk assessments. Staff knowledge and understanding in relation to the Accessible Information Standards (AIS) was poor. AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss were given information in a way they could understand. Records showed that the provider had not considered these standards to support people with their communication needs. Where the provider had identified additional support was required, guidance for staff on how to manage these difficulties was not in place. One to one activities for people that were more isolated in their bedrooms had not been fully recorded to reflect the times, regularity and types of interactions completed.

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

During this inspection we found that the provider had taken actions and made significant improvements. We found these improvements were sufficient to meet the requirements of Regulation 9.

People and their relatives told us they were aware of the process to make a complaint and felt confident their concerns would be addressed appropriately. A relative told us, "[Name of staff] was going on holiday and knew I was upset around some aspects of [Name] care. [Name of staff] told me to tell the manager if there were any queries to ring them. As far as [Name of staff] was concerned they would give up their own time for us." Records showed there had been 11 complaints since our last inspection and responses provided had followed the service's policy and procedures. The complaints policy was displayed in the front entrance and was colour coded to make easy reading. Staff morale had improved since our last inspection, the staff we spoke with told us they felt confident in the leadership at the home and would not hesitate to discuss their concerns with the management team or utilise the whistle blowing process.

Overall care plans were detailed and contained clear information to guide staff. Areas we identified for improvement had little or no impact to people and the provider was taking immediate measures to address them.

For example, one person had been assessed as high risk of developing pressure sores. Their care plan identified no formal monitoring of their positioning changes. It stated that they could move themselves in bed, but the risk assessment advised the person called staff regularly to move them. Staff told us this person did move themselves independently most of the time, but had several health conditions that placed them at a higher risk of skin breakdown. We discussed this with the registered manager who immediately took measures to ensure four hourly observations were put in place. This had no impact to the person as they had been moving independently themselves and they currently had no issues in relation to skin integrity. A second person's choking risk assessment advised no oral health problems, but they had recently had a tooth drop out and were unable to access the dentist due to their condition. The missing information did

not change the overall risk score for this person.

Communication care plans were in place and identified those people with any sensory needs or language barriers. One person's care plan identified their first language, sight and hearing needs as had glasses and a hearing aid in place. A communication risk assessment advised they could communicate verbally and use their call bell, information described how they communicated as this was slowly due to their health condition. Other communication plans detailed hourly observations in place for those people unable to use their call bells. The provider had posters throughout the service informing people and their relatives that alternative formats for information were available should they need them.

A dementia specialist employed by the provider had been attending weekly to improve experiences for those people living with dementia. Support had been given to staff to ensure care plans were reviewed and rewritten in a more person-centred way for each person living at the service. Staff reviewed care and support needs monthly. Every six months meetings were held with the person and any other relatives or advocates that were important to the person. Outcomes from meetings and reviews were clearly recorded. This ensured that people's needs were regularly reviewed and changes updated so that documents were as current as possible.

Staff were involving relatives to complete life histories about people, this information was then used to support staff to deliver person-centred care. One person's life history completed by a relative detailed their preferred name, the name was descriptive of their last employment role where they had looked after other people for many years. We observed staff using this name when interacting with this person and it was clear this person felt comforted by this and responded in a positive way.

Activities were managed and planned between three co-ordinators, one of which had started work recently to support the team. Additional staff were being recruited to this area and awaiting employment checks being completed. Weekly activities had been organised and for the dates we inspected these included; Delivering the daily sparkle newspaper and flower arranging around the home, community picnic, sensory activities, baking flapjacks, exercise class, daily sparkle review and hairdresser appointments were booked for individuals Monday to Wednesdays from 09:30am to 13:30pm.

Group activities were well attended, we observed the baking session and people interacted with one another and the staff using their motor skills whilst singing and chatting to one another. Staff encouraged discussions to reminisce and comments from people included; "I used to bake scones, best eaten warm then the butter melts into them", "Used to make all sorts, biscuits, all sorts" and, "I baked fruit pies." People were peering through the glass oven door to check how their flapjacks were cooking. One person said, "Be a good idea to have a cup of tea while we wait" and joined staff for an impromptu cup of tea whilst sat at the kitchen table. At this point, one person burst into song entertaining everyone with a rendition of "Daisy, Daisy." Both staff and people living at the home joined in the singing, which created an informal and jovial atmosphere.

One of the activities co-ordinators told us, "We are focusing on one to one activities now as the group ones are up and running. We incorporate different daily themes; yesterday was hand massages and last week we did chocolate tasting – ensuring diabetic choices were available for people. Every Monday we walk around in the morning to deliver the weekly activities schedule and weekly sparkle - It's a good opportunity to have one to one time with people to chat and plan things that are of interest to them. Trips out had been planned for the week and included, "Burnby Hall Gardens picnic, Fruit picking at the Balloon Tree Garden Centre. Church services were held in the home and musical entertainment was visiting on two occasions during the week.

Staff were being asked to be mindful and complete meaningful interactions daily with people that were more isolated in their bedrooms. Information was available in people's rooms to support staff when adopting a more person-centred approach. For those requiring additional support to communicate or where people had cognitive impairment each room had a framed A4 sheet of paper with a heading "Hello my name is." This included information about; family, likes and dislikes, ancestry, schools attended, work history, national service, staff, this included life histories, preferred names, likes and dislikes. Further information was included in a "Getting to know me" booklet, this was given to people on admission to the service to help staff get to know them better. This document included; favourite photographs, what has made me, what makes me happy and sad and my preferred entertainment. We saw how staff were using this information to make a difference to people; one person had stated they liked to be clean shaven and tidy, our observations confirmed they were well dressed and very clean shaven. Another person had their favourite music playing in their room. Relatives or staff supported people to create and record their latest memories – these were introduced as a keepsake for relatives to cherish their memories with loved ones.

Feedback from people and their relatives included: "I went into Pocklington last week, and went to The Balloon Tree Nursery and Café on York Road. I enjoy the days out and visiting the Women's Institute choir", "I occasionally join in the trips. I went to Lavender Fields, it was a very nice place, could walk a long way" and "Anything going on, I'll join in. I like music. My step-father was a classical pianist, my brother played violin, I just listened." A relative told us, "My spouse doesn't join in any activities but they like the musical afternoons" and a compliments card from relatives noted, "Thank you to everyone who made the royal wedding day very special. A lot of work must have gone into organising everything and it was very much appreciated. We had a lovely memorable day."

We saw numerous cards with compliments about the staff and management of the service. A dining experience book had also been introduced to capture feedback from people and their relatives. The registered manager arranged regular meetings each month to give people and their relatives time to discuss any issues or concerns. The registered manager told us, "When I first arrived at the service my initial meeting with people and their relatives lasted two and a half hours. People were anxious and various concerns were raised. The more recent meeting only last thirty minutes and we received some positive feedback from both relatives and people living at the service."

Advanced care plans recorded people's preferences to stay at Stamford Bridge for their treatment rather than being admitted into hospital – unless emergency treatment was required. These plans had been discussed collectively with relatives when the person had chosen to involve them. One person had recently passed away and their relatives had sent a touching card which said; "To the manager and staff thank you for being there."

## Is the service well-led?

### Our findings

At the last inspection in April 2018 we found records were inconsistently completed and lacked vital information to guide staff in their judgements. The provider had failed to maintain contemporaneous records which were at times unclear, this posed potential risks to people. The providers systems and processes had failed to identify concerns and address them.

This had resulted in a continued breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (HSCA 2008 (RA) 2014).

During this inspection we found that the provider had taken actions and made significant improvements. We found these improvements achieved compliance to meet the requirements of Regulation 17.

The provider had transferred an experienced registered manager from within the organisation to oversee and manage the service. They had good knowledge of the current issues and knew the service, staff and people well. The registered manager had worked tirelessly with the deputy and regional managers to achieve higher standards throughout the service. People living with dementia were supported in line with best practice guidance and staff continued to work with the supportive approach of dementia specialists employed by the organisation. Senior managers and directors had consistently completed quarterly and monthly audits to work towards enhancing standards across the service. Notifications had been submitted to CQC and the local authorities when required.

Staff morale had hugely improved and this had a positive impact on how the service worked together as a team to raise the standards of care delivered to people. Staff spoke about how the leadership and management within the service had moved forward and made significant changes. Feedback included, "I think it has improved, morale is so much better", "Staff morale is much more positive since we had the last inspection", "The management is really positive. The senior management is more visible in the home and the registered manager mucks in and is always around to support us." Staff told us that they looked forward to coming into work and that professionalism in the service had been restored.

The management team were helpful, open and transparent throughout the inspection. When inspectors requested documentation this was provided immediately, the running of the home was observed to be more organised and there was a calming atmosphere in every area of the service. Staff praised the new registered manager, deputy and regional manager for their supportive approach. Staff feedback included; "[Name of registered manager] is brilliant. Thank goodness [name of registered manager] is back and now here permanently. Managers come down to each unit and are always approachable", "The management is really, really good - the best we have had in a long time. Always say hello to people and staff to let us all know they are there for us. The deputy manager has been so supportive, we didn't have that kind of support in place before" and, "The registered manager is approachable and easy to talk to. The residents seem more settled apart from one or two but overall much better."

Although audits, policies and procedures had been reviewed and updated and significant improvements

made, there was still some additional work required to further review and update some records. Management acknowledged that additional time was required to further update some records and to embed practices in regards to mental capacity and to demonstrate a period of sustained improvement.

Senior management explained how they had focused on improving areas of priority since our last inspection. Through looking at records and discussions with staff and senior management, we could see that the service had started work on some of the areas we highlighted during our inspection. Recording of information for those assessed as a higher risk of malnutrition and/or dehydration had improved significantly. People were closely monitored by staff and regular discussions had been initiated with local health professionals to ensure people's needs were reviewed regularly and supported. Care plans and risk assessments were person-centred and included information around specific health conditions. Best practice tools were utilised to highlight risks to people such as those at risk of developing pressure sores or choking. The regional manager told us that although staff were getting better at recording and documenting information, this would be an area of focus for the management team to monitor and address.

Significant improvements had been made throughout the service, which were supported by feedback from health professionals, staff and people using the service. We identified some areas for improvement, such as recording and guidance for topical and 'when required' medicines. In addition, some areas of practice required further embedding to demonstrate improvements could be sustained. The registered manager agreed to progress these areas.

In addition to record keeping, communication had also improved. Regular meetings for staff encouraged openness and transparency when addressing issues or concerns. Activities staff had discussed involving local groups in the July staff meeting. Plans were in place for people to have the opportunity to interact with the local school children and Brownies. This showed that management were progressing community links to enhance people's lives and ensuring risk assessments are in place before doing so.

We observed the daily stand-up meeting held to ensure staff had the opportunity to discuss their concerns and supported the registered manager to gain important oversight about the service. Staff in each area of the home discussed topics in relation to pressure care, nutrition and hydration, incidents, district nurse recommendations or updates, falls, speech and language therapist visits for those at risk of choking and people currently on antibiotics. The registered manager discussed events for the day which included; activities and appointments for people. Immediately after the meeting the registered manager took a copy of the written notes and handed them to the attending staff. This level of detail ensured that staff could concentrate on the discussion as they were not distracted by writing. It also acted as a reference point for staff to refer to which made sure things were followed up and acted upon.

Positive feedback was received from people who used the service, relatives, staff and visiting health care professionals. People and relatives were encouraged to voice their opinions and suggestions were taken on board to improve the services available to people. Relatives meeting minutes showed the registered manager had been open and honest about the findings in our last inspection. They had reassured people that work was underway to improve areas identified within the report and fully answered any questions of concern. People had requested changes to the menu and these had been accommodated. Without exception staff, people and their relatives told us they felt listened to and valued for their input. Management had worked hard to ensure everyone was involved with any improvements they were proposing. Discussions supported staff to make necessary changes. For example, activities co-ordinators had weekly meetings with dementia specialists to discuss ideas they could implement with guidance to meet best practice guidelines for those people living with a dementia related condition. One person said, "The home takes on board any suggestions and acts on them" and a second person told us, "We have

regular meetings. They listen to me and take suggestions on board."

Recruitment initiatives encouraged staff to recommend carers and nurses to the service and bonuses were given at certain periods of employment to celebrate longevity of service. Staff told us they had recently received a voucher as a thank you for their hard work and this had made them feel valued. Quality assurance systems and audits identified where improvements needed to be made and noted good practice throughout the service so this could be communicated and celebrated with staff.

The registered manager received updates from the various key partners, such as the Independent Care Group. The registered manager told us they were due to attend first 'partners in care forum' in September 2018. This gives providers the opportunity to meet and share information about local practices, initiatives and networking opportunities. The registered manager was keen to share information with people and their relatives about research opportunities so people could choose to share their experiences and views. Barchester run their own six-monthly conference and distribute weekly bulletins which include sharing corporate initiatives and key changes to legislation.

We saw lots of evidence of partnership working and records from the local authorities' assessments and observations supported good practice across the service. For example, whilst observing one person the local authority had noted they had shown signs of agitation. The staff had responded and used various distraction techniques to put the person at ease. A visiting health professional said, "It is better, more stable. I have cut my visits from two a week to one now and GP's are not getting additional calls. [Name of registered manager] is on the ball and gets things done. I have noticed it is calmer. Residents and staff seem much happier." A nurse employed by the service told us, "I think it is much better now. The management are supportive and we see the regional manager a lot. We work as a team."