Norton Care Limited

The Grange Nursing Home

Inspection report

Watershaugh Road
Warkworth
Morpeth
Northumberland
NE65 0TX

Tel: 01665711152
Website: www.thegrangewarkworth.co.uk

Date of inspection visit:
27 November 2015
03 December 2015
04 December 2015
07 December 2015

Date of publication:
22 January 2020

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

Summary of findings

Overall summary

Prior to our inspection, we received information of concern about a serious incident which had occurred at the home. We took this information into account when planning our inspection.

We commenced our inspection on 27 November 2015. The inspection was unannounced which meant that staff and the provider did not know that we would be visiting. We visited the service out of hours at 6.30pm on the first day of our inspection. We carried out three further visits to the home on 3, 4 and 7 December 2015 to complete the inspection.

The home was last inspected in March 2015. We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to consent to care and treatment; management of medicines; safety and suitability of premises and assessing and monitoring the quality of service provision. The provider submitted an action plan which stated what action they were going to take to improve in these areas. They stated that the actions and improvements would be completed by July 2015.

At this inspection, we found that the registered provider had not followed their plan and legal requirements had not been met.

The Grange Nursing Home is situated in Warkworth, Northumberland and provides accommodation for up to 23 older people who require nursing or personal care. There were 22 people living at the home at the time of our inspection.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

Some staff raised concerns about how a recent incident had been dealt with. The manager confirmed that the correct procedures had not been followed and she had not notified the person's care manager or ourselves. We are investigating this incident and will report on any action once it is complete.

Following our inspection, the local authority's safeguarding adults team carried out their own investigation into this incident. Allegations of neglect against the registered manager were upheld.

We found that systems to protect people from the risk of abuse were not fully in place. We had not been notified of one safeguarding incident. We found the provider had not taken appropriate action to fully protect people following the recent incident.

We checked the premises and saw that some of the window restrictors which had been fitted to upstairs windows did not conform to the Health and Safety Executive (HSE) design guidelines. These could be

overridden and the windows opened fully. Following our inspection, the provider informed us that this had been actioned.

The adaptation, design and decoration of the premises did not fully meet the needs of people who lived with dementia.

There were no designated sluice facilities and staff were manually washing continence equipment in an unused bathroom on the first floor. This procedure increased the risk of cross infection.

Nine of the 13 people who used bed safety rails to reduce the risk of them falling out of bed did not have any bed rail bumpers fitted [protective padding]. This omission meant that people were not fully protected from the risk of injury.

Staff told us that prior to our visit they transferred some people to the shower room using shower chairs. It was not clear whether the shower chairs were designed for the transportation of people around the home. One shower chair had been disposed of following the serious incident and the other shower chair had been stored in the loft. The maintenance man told us that checks had not been carried out to ensure the safety of the shower chairs. This meant that equipment used in people's care had not always been assessed as being appropriate or safe.

There were shortfalls in the management of medicines. One person had been given an incorrect dosage of Warfarin, a medicine used to prevent blood clots. We found that it was not always possible to ascertain whether people had had their medicines as prescribed.

We found shortfalls in the recruitment records we checked. These did not always document fully the recruitment checks and decisions which had been undertaken.

Staff told us that there were sufficient care staff to support people. They told us however, that more support would be appreciated at tea time since kitchen staff left at 2.30pm and they had to organise the tea time meal.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests' it also ensures unlawful restrictions are not placed on people in care homes and hospitals. The manager had submitted DoLS applications to the local authority to authorise. We found however, that decision specific mental capacity assessments were not in place to document decisions such as those relating to people's finances, health checks and restrictions such as bed rails. The manager was unaware of mental capacity assessments.

Some staff told us that they felt supported; others told us that more support was required. We read supervision records and found some inconsistencies and irregularities regarding the dates when these sessions had been held. This meant that it was not possible to ascertain whether staff were provided with the appropriate support and that supervision sessions were carried out as planned.

Staff told us that training was available. The manager provided us with information about staff training. We had concerns about moving and handling procedures and found that there was no designated moving and handling coordinator to advise on moving and handling procedures at the home.
We observed the tea time period and noticed that discreet support was provided and people told us that

they enjoyed their meals at the home. There were shortfalls however, with two people's care plans which we viewed in relation to their dietary requirements.

We observed that care was provided with patience and kindness. Although we discovered that people were transferred to the shower room in a way which did not promote their privacy and dignity.

An activities coordinator was employed to help meet the social needs of people who lived at the home. People and relatives told us that activities provision was good at the home.

The manager carried out audits on a number of different areas of the home including care plans, medicines and infection control. It was not always clear what actions had been taken in relation to any shortfalls identified. We noted that "quality assurance" and "food" questionnaires were undertaken to ascertain the opinions of people and their representatives. We saw however, that these were not dated and there was no overview of the findings.

We found serious shortfalls in the maintenance of records. We found irregularities, inconsistencies and factual inaccuracies in some of the records we viewed relating to people's care, records relating to staff and those relating to the management of the service. Following our inspection, we wrote to the provider using our regulatory powers to request further information that we were unable to obtain during our inspection.

Since April 2015, adult social care providers have to comply with the Duty of Candour regulation. This regulation states that providers must be open and transparent with people and those acting lawfully on their behalf about their care and treatment, including when it goes wrong. Some staff and a relative felt that there had been a lack of openness and transparency regarding one particular incident. We also found inconsistencies and irregularities with regards to information we received from the manager and the records we viewed during the inspection in relation to this accident
.
We found that neither the provider or manager had not notified us of one safeguarding incident. In addition, we had not been informed about one serious injury. The submission of notifications is required by law and enables us to monitor any trends or concerns and pursue any specific matters of concern with the provider. At this inspection, we found concerns with many aspects of the service. This meant that the provider did not have effective systems in place to ensure they were able to meet the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Following our inspection, we wrote to the provider using our regulatory powers to request that they submit a weekly report to the Commission, stating what actions had been taken to address the concerns we raised. Although the provider submitted several reports, these were not submitted weekly. This issue is being followed up.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of this report. We found one breach of the Care Quality Commission Registration Regulations 2009. This related to the notification of other incidents. This is being followed up and we will report on any action once it is complete.

We took urgent regulatory action in relation to the registered manager.

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.

We found that systems to protect people from the risk of abuse were not fully in place. CQC had not been notified of one safeguarding incident. We found that the provider had not taken appropriate action to fully protect people and staff following one recent accident.

A system to ensure the safe administration and effective management of medicines was not in place.

There were concerns with certain aspects of the premises and equipment. Risks concerning the premises and equipment had not been fully assessed.

Recruitment records did not always document the recruitment checks and decisions which had been undertaken.

Is the service effective?

Inadequate

The service was not effective.

The requirements of the Mental Capacity Act 2005 were not met.

There were some inconsistencies and irregularities regarding when supervision sessions had been held. This meant that it was not possible to ascertain whether staff were provided with the appropriate support and that supervision sessions were carried out as planned.

The adaptation, design and decoration of the premises did not fully meet the needs of people who lived with dementia.

People were provided with support to meet their nutrition and hydration needs. Two people's care plans however, did not document fully, their dietary requirements and support required.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring.

We observed that care was provided with patience and kindness. Although we discovered that people had been transferred to the shower room in a way which did not promote their privacy and dignity.

Records did not fully evidence that people and relatives were involved in their care and treatment.

Is the service responsive?

Inadequate

The service was not responsive.

The manager informed us that the correct procedures had not been taken following a recent accident. We found inconsistencies and irregularities from staff and the records we viewed about whether one person had been in pain. There was no recognised tool in place in the care files we examined for the assessment of pain for those individuals who could not verbalise their feelings.

Care plans sometimes did not include all the information required to enable staff to provide appropriate care and treatment.

A complaints procedure was in place. We noted that the manager had indicated that the local authority and CQC had been made aware of the complaint. The provider had not notified CQC of the complaint or the concerns raised.

An activities coordinator was employed to help meet the social needs of people who lived at the home. People and relatives told us that activities provision was good at the home.

Is the service well-led?

Inadequate

The service was not well-led.

Some staff and one relative felt that there had been a lack of openness and transparency regarding one particular accident and the provider had not fulfilled their duty of candour.

We found serious shortfalls in the maintenance of records. We found irregularities, inconsistencies and factual inaccuracies in some of the records we viewed relating to people's care, records relating to staff and those relating to the management of the service.

The provider had not always submitted notifications to us in line with their responsibilities and legal requirements.

At this inspection, we found concerns with many aspects of the service. This meant that the provider did not have effective systems in place to ensure they were able to meet the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Grange Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

Prior to our inspection, we received information of concern about a specific incident which had occurred at the home. We took this information into account when planning our inspection.

The inspection team consisted of two inspectors and an inspection manager. We also sought advice from a CQC pharmacy inspector.

We commenced our inspection on 27 November 2015. The inspection was unannounced which meant that staff and the provider did not know that we would be visiting. We visited the service out of hours at 6.30pm on the first day of our inspection. We carried out three further visits to the home on 3, 4 and 7 December 2015 to complete the inspection.

We spoke with the registered manager, two nurses, an agency nurse, six care workers, the cook and the maintenance man.

We talked with four people, four relatives and two visitors to find out their opinions of the service.

We examined four people's care plans and checked five staff recruitment files, training and supervision records and documents relating to the management of the service.

We conferred with staff from the local authority contracts and safeguarding teams and the local Clinical Commissioning Group throughout our inspection. We also consulted with the community matron for nursing homes; a reviewing officer, a care manager and infection control practitioner from the local NHS Trust and a GP to obtain their opinions about the home and the care and treatment provided.

We gave the manager a poster to display in the home about the inspection on our first visit. The poster was displayed during and after the inspection to encourage people who lived at the home, their representatives and anyone else who was involved in the service to provide feedback to CQC about the service.

Inadequate

Is the service safe?

Our findings

Prior to our inspection, we received information of concern about a specific health and safety incident which had occurred at the home. Neither the provider or registered manager had notified us of this incident.

We found that one person had been involved in a serious incident whilst using equipment in the service. The equipment involved in the incident had been destroyed on the instructions of the manager. This action prevented us from reviewing the safety and suitability of the equipment involved. In addition, medical advice had not been sought immediately for the person. We spoke with the manager about this issue. She told us that the correct procedures had not been followed and she had not notified the person's care manager or ourselves and this had been an oversight on her behalf.

We are investigating this incident and we will report on any action once it is complete. Following our inspection, the local authority's safeguarding adults team carried out their own investigation into this incident. Allegations of neglect against the registered manager were upheld.

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

At our previous inspection we found a breach in the regulation relating to the premises. Window restrictors had not been fitted to windows; there were no designated facilities for the cleaning and disinfection of continence equipment and concerns highlighted on the electrical installations report had not been fully completed.

At this inspection, we spent time looking around the premises. We found that some improvements had been made. New flooring had been fitted in some rooms and remedial work on the electrical installations system had been carried out. We saw that window restrictors had also been fitted. Six of the restrictors which had been fitted to upstairs windows however, did not conform to the Health and Safety Executive (HSE) design guidelines because they could be overridden. We saw that the windows opened fully and relevant risk assessments had not been undertaken. Serious injuries and fatalities have occurred when people have fallen from or through windows in health and social care premises. Following our visits, the provider informed us that this had been addressed.

There was an open staircase which people had access to. This risk of people accessing the stairs and falling had not been assessed. We read recent handover records which stated that one person had been "Wandering ++ [a lot] up the stairs."

At our previous inspection we found that there was no sluice machine for the cleaning and disinfection of continence equipment. We stated, "The registered manager told us they had requested a quote for a new sluice facility to be fitted and this had been classified as 'urgent'." At this inspection we found that a sluice facility had still not been installed and staff were manually cleaning commodes in an unused bathroom on the first floor. We spoke with a member of staff from the local NHS Trust regarding this issue. They said that

this method of cleaning and disinfection of continence equipment was not suitable. This meant that systems were not fully in place to reduce the risk of cross infection.

We checked equipment at the home. We found that nine of the 13 people who used bed safety rails to reduce the risk of them falling out of bed did not have any bed rail bumpers fitted [protective padding]. Bumpers are used to prevent any injuries or the entrapment of limbs. The manager told us that she would purchase more bed rail bumpers immediately. This omission meant that people were not fully protected from the risk of injury.

Staff told us that prior to our visit they had transferred some people to the shower room using shower chairs. There was no evidence to confirm that shower chairs were designed for the transportation of people around the home. One shower chair had been disposed of following the serious incident and therefore we could not assess its suitability or condition. The other shower chair had been in use on the first day of the inspection but was subsequently stored in the loft. The maintenance man told us that checks had not been carried out to ensure the safety of the shower chairs and no relevant manufacturer's guidance was available. This meant that equipment used in the transportation of people around the home prior to the incident, had not been checked to ensure its safety and suitability.

Staff informed us that at the time of the incident the person's call bell with emergency buzzer was located behind a wardrobe which meant that they could not access it. They explained that they had to press the emergency buzzer in another room. We noticed that the call bell and emergency buzzer had been re-sited following the accident and was now accessible to staff. This was confirmed by the maintenance man. This meant however, at the time of the accident, equipment to summon emergency support had not been fully accessible.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.
Risk assessments had been completed relating to identified risks such as the use of the shower chairs. We noted however, that the handwritten dates of some of these risk assessments did not match the computer generated dates. These inconsistencies meant it was not clear when these risk assessments had been written and whether they had been in place prior to the incident.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

We checked safeguarding procedures at the home. The health and safety accident had been reported to the local authority two weeks following the incident and the person involved had been placed into safeguarding. The provider had not notified us of the local authority's safeguarding team's involvement. This meant there had been no overview or scrutiny by the Commission to check whether the appropriate action had been taken to safeguard the individual.

Some staff raised concerns about the conduct of the member of staff who had been investigating the incident and who had been directly involved. Some staff were not aware of the whistleblowing policy. The term whistleblowing can be defined as raising a concern about any wrong doing within an organisation. One member of staff had requested a meeting with the provider. We read that the manager had written back to state that all contact needed to be through herself as manager. This meant that staff were not always able to raise concerns without the manager's involvement.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Safeguarding service users from abuse and improper treatment.

At our previous inspection, we found a breach relating to the management of medicines. At this inspection, we found that although some improvements had been made, a safe system to manage people's medicines was not fully in place.

Medicines were not always carried forward at the beginning of the month which meant it was not possible to ascertain how many tablets should be in stock and that this matched with the number of tablets which staff had administered. In addition, the amount of variable dose medicine was not always recorded. For example, whether one or two paracetamol tablets were administered. This is necessary so that staff members have accurate up to date information, and to make sure that there is a clear record of the medicines administered at the home.

We noted that two people were prescribed a medicine which helped prevent blood clots called Warfarin. People taking Warfarin need to be monitored closely to check their blood clotting ability. The manager had typed up one person's Warfarin dosage instructions. We noticed however, that this information did not match the dosage instructions received from the hospital. We saw that a nurse had administered the wrong dose of Warfarin on one occasion. The manager immediately contacted the hospital Warfarin clinic to seek advice regarding this error. The medicine administration record (MAR) for a second person taking Warfarin was unclear. An entry suggesting a dose had been given incorrectly was crossed out. However, because records dealing with the stock of tablets held by the home were not up to date, we could not check whether the dose had been given in error, or the MAR marked incorrectly.

We noted that there was no evidence that one person had received their osteoporosis medicine for two weeks. This medicine was prescribed weekly. Another person was prescribed twice daily pain relief. We noted that this was only administered once daily. These omissions meant that medicines were not always administered as prescribed. The manager told us that she would address this immediately.

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

We found shortfalls and inconsistencies in the recruitment records we viewed. Dates of references were not always included. This meant it was not possible to check whether references had been obtained prior to staff starting work to ensure that staff were suitable to work with vulnerable people. In addition, we found gaps and inconsistencies for the recording of recruitment checks for a volunteer.

One staff member told us that she had left the home in May 2015 and decided to return in August 2015. We noted that recruitment checks had not been carried out when the staff member came back to work at the home. We noted that an interview record had been completed for this staff member in October 2015. The manager and staff member were unable to inform us why they had been interviewed two months after their return date.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

People, staff and relatives told us that there were enough staff to look after people. Some staff informed us however, that more support would be appreciated over the tea time period in the kitchen. They explained that kitchen staff left at 2.30pm which meant that they had to "sort out" the tea time meal which had been pre-prepared by the cook for them to heat up and give to people. Staff told us, and our own observations

confirmed that most people remained in the lounge for "high tea." The manager told us that people did not like to go to the dining room at tea time and preferred to stay in the lounge. We were unclear however, whether this was because staff were not available to support people to the dining room since they were in the kitchen organising the tea time meal.

We spoke with the manager about this issue. She told us that this had not been identified as an issue, but would speak to staff again about any concerns they had regarding the tea time staffing period.

Inadequate

Is the service effective?

Our findings

At our last inspection we found a breach in the regulation relating to consent. There had been a delay in ensuring people were only deprived of their liberty in a safe and correct way which was authorised by the local authority, in line with legislation. Records did not clearly demonstrate that consent to care and treatment was always sought in line with the Mental Capacity Act 2005.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Livery 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.

At this inspection, DoLS applications had been sent to the local authority for authorisation. We found however, there was a lack of documented evidence to demonstrate that care and treatment was delivered in line with the Mental Capacity Act 2005.

We noted that specific, individual mental capacity assessments had not been carried out for important decisions for example, healthcare checks, end of life care and the use of bed safety rails. This meant that people's rights to make particular decisions had not been protected, as unnecessary restrictions may have been placed on them.

We spoke with the manager about this issue. She was unaware, despite advice given at our last inspection, of mental capacity assessments or their use.

We noted that consent forms were in place for the use of bed safety rails. Some of these had been signed by people's relatives. However, we received information of concern that these consent forms were not accurate. One relative told us that their signature had been forged.

It was not clear whether relatives involved in people's decisions about health care decisions had a lasting power of attorney (health and welfare). LPA is a legal tool which allows people to appoint someone (known as an attorney) to make decisions on their behalf if they reach a point where they are no longer able to make specific decisions. There are two types of LPA; property and financial affairs and health and welfare.

This meant evidence was not available to confirm whether an attorney had been appointed or what type of LPA was held to ensure the correct attorney was involved in the correct decisions.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

At our previous inspection, we found that the adaptation, design and decoration of the premises did not fully meet the needs of people who lived with dementia. We made a recommendation that the design and decoration of the premises was based on current best practice in relation to the specialist needs of people living with dementia.

The National Institute for Health and Care Excellence (NICE) states, "Health and social care managers should ensure that built environments are enabling and aid orientation."[NICE, Dementia - Supporting people with dementia and their carers in health and social care, November 2006:18].

At this inspection, we found that no improvements had been regarding the suitability of the environment in relation to those who had a dementia related condition. Most of the corridors were painted in the same colour with few discernible features to aid orientation. We noticed some of the furnishings appeared to confuse certain people. The lounge carpet was highly patterned and we saw one person bending down to pick what he thought were flowers from the carpet. The manager told us that a survey had been carried out with regards to bedroom door colours, but no work had been carried out as yet to adapt the environment so it met the needs of people who lived with dementia.

We noticed that one person's bedroom had a bolt on the outside of their door. The manager told us that she was unaware of the presence of this bolt or why it was there. She said that she would organise for the maintenance man to remove it.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

Some staff told us that they felt supported; others told us that more support was required. We read supervision records and found some inconsistencies, irregularities and factual inaccuracies regarding the dates when these sessions had been held. One staff member told us that she had not been working at the home on the date of one of their documented supervision sessions. The manager stated that the administrator prepopulated the dates of supervision sessions and the dates these were held were not always accurate. This meant that it was not possible to ascertain whether staff were provided with the appropriate support and that supervision sessions were carried out as planned.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Staff told us that they felt there was sufficient training provided to enable them to carry out their duties. Although staff had completed moving and handling training, there was no appointed moving and handling coordinator to advise on moving and handling procedures at the home.

We checked how people's nutritional needs were met. We found shortfalls with two people's care plans in relation to their diet and nutrition and support required. We read a recent handover entry on 19 November 2015. This stated that one person had "Choked on bacon." This incident had not been recorded in the person's daily records. Staff said that the person was now receiving a soft diet. This was not reflected in the person's care plan. This omission placed the person at risk of further choking episodes.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014. Safe care and treatment.

The manager told us that the clinical lead had referred the person to the speech and language therapist on the last day of our inspection.

Staff informed us that sometimes meals for people who required a soft diet were not organised at tea time. They explained that they just had to find whatever was available in the kitchen, such as tinned spaghetti. We looked at the menus and saw that it was not always clear what was available for people who required a soft diet. In addition, we read a book which was kept in the kitchen that recorded which meals had been provided. This had not been fully completed and also did not specifically identify what had been provided for those who required a soft diet.

We noted that another person was seen by the dietitian in September 2015, who provided specific guidance about the person's diet. We saw that this information was not included in the individual's care plan. This meant that the person may not receive a suitable diet which met their needs.

We observed the tea time period on one of the days we visited. Staff told us that people preferred to stay in the lounge for high tea. We saw that discreet support was provided and staff encouraged people to be independent with eating and drinking. One person needed full support with eating and drinking, we saw that appropriate assistance was provided.

Requires Improvement

Is the service caring?

Our findings

Prior to our inspection, we received information of concern that a specific incident had not promoted one person's privacy and dignity.

Staff told us that some people were transferred on a shower chair to the shower room. This included taking people between floors in the home's passenger lift. They informed us that people were "wrapped in towels" whilst being transported through the home on the shower chair and no night wear or clothing was worn underneath. We considered that this procedure did not promote people's privacy or dignity.

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

We found shortfalls in the records to demonstrate that people and their representatives were involved in people's care and treatment. Although quality assurance surveys were carried out, these were undated. In addition, concerns were raised about the accuracy of consent forms. One relative with whom we spoke stated and was very clear that their signature had been forged.

People and relatives with whom we spoke told us that staff were caring. Comments included, "The girls are wonderful, so caring," "I cannot fault the care," "They [staff] are always very polite," "The care has been wonderful" and "She is well looked after."

We read compliments which had been received from relatives about the care their family members had received. On relative stated, "Everyone showed respect and love to mum, looking after her needs in such a caring way. Thank you for your care for us as a family." Another relative had written, "I write to thank you all for the kind, caring and diligent care that you have all given to my brother…This contributed to make the last months of life so much more comfortable, consistent and loving."

We saw positive interactions between people and staff. One person reached out for a hug from one member of staff. The staff member hugged them and said, "You're like me you love your hugs." The person nodded and smiled. One person became upset and the staff member knelt beside them and reassured them. The staff member said, "Look, I'll sit here beside you and we can talk." Another person was calling out, a staff member said, "Would you like a nice cup of tea." The person said, "Oh yes."

There was lots of singing and laughter throughout our inspection. People enjoyed singing and staff joined in too. We observed that everyone looked well presented. Care had been taken with people's hair and clothing.

Inadequate

Is the service responsive?

Our findings

Prior to our inspection, we received information of concern about a specific health and safety incident which had occurred at the home. Concerns were raised that responsive action had not been taken. We found these concerns to be substantiated.

The manager informed us that the correct procedures had not been taken following a recent incident. Medical advice had not been sought in a timely manner and the person's care manager had not been informed until two weeks later.

It was also unclear from the records we viewed as to whether the person had seen the GP following the incident and injury. The manager confirmed that the person had not seen the GP immediately after the accident and had not been visited until over two weeks later.

We found inconsistencies and irregularities in the accounts and recollections of staff and the records we viewed about whether one person had been in pain. There was no recognised tool in place in the care files we examined for the assessment of pain for those individuals who could not verbalise their feelings. The manager told us that she would address this immediately.

We noticed that another person had sustained a serious injury. We had not been notified of this injury. The home had been informed of a previous injury which could predispose the person at being at risk of further injuries. We saw that a care plan had been put in place following the incident. This incident is being followed up and we will report on any action once it is complete.

One person had a urinary catheter fitted. Urinary catheterisation is a procedure where a thin, flexible tube called a catheter is inserted into the bladder to drain it. We noted that the size of catheter which should be used was not recorded in the person's care plan and staff had used different catheter sizes when recatheterising the individual. The manager told us that staff should be recording all catheter care in the catheter booklet which was located in their care plan. We saw however, that staff had not recorded recent catheter changes in this book.

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

There was a complaints procedure in place. We read that one complaint had been received on 25 November 2015. The manager had recorded under the actions completed, "Safeguarding and CQC." However, the manager had not informed us of the concerns raised.

An activities co-ordinator was employed to help meet the social needs of people who lived at the home. We saw that people were engaged in activities throughout our inspection such as quizzes, baking and reminiscence therapy. The activities coordinator approached all activities with enthusiasm and tried to involve everyone in activities which interested them. We read that people had visited an exhibition of the

Tower of London poppies which was displayed at a local colliery museum. One relative said, "The activities are very good."

Inadequate

Is the service well-led?

Our findings

At our previous inspection in March 2015, we found that the arrangements in place for quality assurance and governance were not effective. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations.

Following examination of records and discussion with the manager, we found that the provider had not followed their plan and legal requirements had not been met.

We found serious shortfalls in the maintenance of records. We found irregularities, inconsistencies and factual inaccuracies in some of the records we viewed relating to people's care, records relating to staff and those relating to the management of the service. One relative told us that staff had forged her signature on the bedrails consent form.

We found that additional information had been added to one person's care records which had not been present when we first checked their records. Hand written dates on risk assessments did not correspond with the computer dated entries and the dates on supervision records did not document the date when the actual supervision session had been carried out. We read a comment which had been written in the diary following the first day of our inspection. This stated, "[Name of staff member] pls ring all nurses, tell them CQC inspection all next week, need care plans up to date."

The manager carried out a number of audits to check the quality of the service provided. These included checks of care plans and infection control systems. We noted however, that these did not always highlight the concerns which we found. We read audits which stated that the care plans demonstrated the provisions of the MCA had been followed. We found however, that the principles of the MCA were not always followed.

The provider carried out visits to the home and completed records of his visits. We read one visit report dated 11 June 2015. This stated, "Sluice room to be fitted." We had highlighted the lack of sluice facilities at our previous inspection. At this inspection, we saw that sluice facilities were still not in place.

Following our inspection, we wrote to the provider using our regulatory powers to request that they submit a weekly report to the Commission, stating what actions had been taken to address the concerns we raised. Although the provider submitted several reports, these were not submitted weekly. This issue is being followed up.

We read the minutes from the most recent "family and friends" meeting. These stated, "[Name of relative] asked when the new carpet would be fitted in the lounge as it seems a while since this was discussed." No answer was given at the meeting and we saw that a new carpet in the lounge had not been fitted. We had raised this as a concern at our last inspection in March 2015 because the carpet was highly patterned and did not meet the needs of people who lived with dementia.

We asked how the views of people and relatives were obtained. The manager told us that questionnaires called, "Living in the home: service user/relatives' feedback questionnaires" were given out however, these were often not completed and returned. We asked to see
completed, "Living in the home" questionnaires, but none were available and we were provided with a blank copy.

We noted that "quality assurance" and "food" questionnaires had been completed. Many of these were undated, so it was unclear when they had been carried out. The manager told us that the activities coordinator completed these with people. We asked whether information from these surveys was analysed and feedback provided to people and relatives. The manager told us that she did not carry out an analysis of any feedback at present. This meant there was no overview of the feedback which had been received or what actions had been taken. We read that one person had stated in response to the question, "How could the service be improved?" "By taking all the outside doors off." It was not clear what action had been taken in response to this feedback or whether further discussion had been carried out to ascertain what the individual meant by this statement.

At this inspection, we found serious concerns with many aspects of the service. This meant that the provider did not have effective systems in place to ensure they were able to meet the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

We spoke with one person's relative who told us that there had been inconsistencies between the information they had received and records they had reviewed with regards to the recent incident at the home. The relative said, "They have not been honest at all – not open or honest." We also found inconsistencies and irregularities with regards to information we received from the manager and the records we viewed during the inspection in relation to this incident.

This was a breach of Regulation 20a of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Duty of Candour.

The intention of this regulation is to ensure that providers are open and transparent with people who use services and those acting lawfully on people's behalf. It also sets out specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

We found that the provider had not notified us of one safeguarding incident. In addition, we had not been informed about a serious injury to a person who used the service. The submission of notifications is required by law and enables us to monitor any trends or concerns and pursue any specific matters of concern with the provider.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

We have referred our concerns to the local authority, Northumberland Clinical Commissioning Group and the Nursing and Midwifery Council.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were transferred to the shower room in a way which did not promote their privacy and dignity. Regulation 10 (1)(2)(a).

The enforcement action we took:

We took enforcement action against the provider but this did not proceed as improvements were made. We also took action against the registered manager which proceeded and their registration with CQC was cancelled.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure staff adhered to the requirements of the Mental Capacity Act 2005. Regulation 11 (1)(3).

The enforcement action we took:

We took enforcement action against the provider but this did not proceed as improvements were made. We also took action against the registered manager which proceeded and their registration with CQC was cancelled.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People living at the service were not always provided with safe care and treatment. Risks had not been adequately assessed. This exposed people to the risk of harm. People were not protected against the risks associated with medicines because the provider failed to have appropriate arrangements in place to manage medicines. Regulation 12 (1)(2)(a)(b)(d)(e)(f)(g)(i).

The enforcement action we took:

We took enforcement action against the provider but this did not proceed as improvements were made. We also took action against the registered manager which proceeded and their registration with CQC was

cancelled.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded; or protected from the risk of abuse. Regulation 13 (1)(2)(3).

The enforcement action we took:

We took enforcement action against the provider but this did not proceed as improvements were made. We also took action against the registered manager which proceeded and their registration with CQC was cancelled.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The adaptation, design and decoration of the premises did not fully meet the needs of people who lived with dementia. Regulation 15 (1)(2)(c).

The enforcement action we took:

We took enforcement action against the provider but this did not proceed as improvements were made. We also took action against the registered manager which proceeded and their registration with CQC was cancelled.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People who used the service and others were not protected against the risks of inappropriate or unsafe care because an effective system for monitoring the quality and safety of the service was not in place. The provider failed to ensure accurate records were maintained in respect of people who used the service, staff and the management of the home. Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(e)(f).

The enforcement action we took:

We took enforcement action against the provider but this did not proceed as improvements were made. We also took action against the registered manager which proceeded and their registration with CQC was cancelled.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

Diagnostic and screening procedures	Recruitment procedures were not operated effectively. Regulation 19 (1)(a)(2)(a)(3)(a).

The enforcement action we took:

We took enforcement action against the provider but this did not proceed as improvements were made. We also took action against the registered manager which proceeded and their registration with CQC was cancelled.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour
Diagnostic and screening procedures	We found that action was not always taken to ensure that the service was operated in an open and transparent way in relation to care and treatment provided to people. Regulation 20 (1)(2)(a)(b)(3)(a)(b)(c).

The enforcement action we took:

We took enforcement action against the provider but this did not proceed as improvements were made. We also took action against the registered manager which proceeded and their registration with CQC was cancelled.