Care Quality Commission

Akari Care Limited

Philips Court

Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection carried out on 27 November 2015.

We last inspected Philips Court in July 2014. At that inspection we found the service was meeting all the legal requirements in force at the time.

Philips Court is a 75 bed care home that provides personal and nursing care to older people, including people who live with dementia or a dementia related condition. At the time of inspection there were 74 people living there.

A registered manager was in post. 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.

Summary of findings

The environment was well designed to help people who lived with dementia to be aware of their surroundings and to remain involved. However, there was not a good standard of hygiene and areas of the premises were showing signs of wear and tear.

People's care records did not accurately reflect the care and support provided by staff. Staff knew the people they were supporting well. Care was provided with kindness and people's privacy and dignity were respected. There were activities and entertainment available for people

People said they were safe and staff were kind and approachable. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Systems were in place for people to receive their medicines in a safe way. People had access to health care professionals to make sure they received appropriate care and treatment. Appropriate training was provided and staff were supervised and supported

Philips Court was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to.

People had the opportunity to give their views about the service. There was regular consultation with people and/or family members and their views were used to improve the service. The home had a quality assurance programme to check the quality of care provided. However, the systems used to assess the quality of the service had not identified the issues that we found during the inspection with regard to record keeping.

Staff and relatives said the management team were approachable. Communication was effective to ensure staff and relatives were kept up to date about any changes in people's care and support needs and the running of the service.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Not all aspects of the service were safe.

Checks were carried out regularly to ensure the building was safe and fit for purpose. The standard of cleanliness around the building was not always satisfactory.

People told us they felt safe. Staff were appropriately recruited.

Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

Policies and procedures were in place to ensure people received their medicines in a safe manner. However, detailed records were not in place for supporting people who displayed distressed behaviour and who may have required medicines at times for agitation and distress.

Is the service effective?

Good

The service was effective.

The environment was showing signs of wear and tear in some areas of the home. It was well-designed to help people who lived with dementia, or dementia related conditions remain orientated and stimulated.

Staff were supported to carry out their role and they received the training they needed.

Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a balanced diet to meet their nutritional needs.

Is the service caring?

Good

The service was caring.

People and their relatives said the staff team were caring and patient as they provided care and support.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

The service was caring.

People and their relatives said the staff team were caring and patient as they provided care and support.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

Summary of findings

There was a system for people to use if they wanted the support of an advocate. Advocates can represent the views of people who are not able to express their wishes.

Is the service responsive?

Requires improvement

The service was not always responsive.

Staff were knowledgeable about people's needs and wishes. Records did not always reflect the care and support provided by staff.

There was a variety of activities and entertainment to stimulate people and to help keep them engaged.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Requires improvement

Not all aspects of the service were well-led.

A registered manager was in place. The manager was passionate about the care of people who live with dementia. Staff told us the manager was supportive and could be approached at any time for advice.

People who lived at the home and their relatives told us the atmosphere was good.

The home had a quality assurance programme to check on the quality of care provided. The systems used to assess the quality of the service had not identified the issues that we found during the inspection.

Philips Court

Detailed findings

Background to this inspection

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

This inspection took place on 27 November 2015 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist nursing advisor 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 for older people. The specialist advisor helped us to gather evidence about the quality of nursing care provided.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams. We also contacted health and social care professionals who worked with the service. We received no information of concern from these agencies.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with ten people who lived at Philips Court, nine relatives, the registered manager, two registered nurses, ten support workers including one senior support worker, the activities organiser, a domestic person, two members of catering staff and a visiting health care professional. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care records for ten people, recruitment, training and induction records for four staff, seven people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the acting manager had completed.

Requires improvement

Is the service safe?

Our findings

We had concerns that records did not accurately reflect the care that people received.

Risk assessments that were in place were regularly reviewed but many of the evaluations did not include any detail about the person's current situation other than stating "No change," where there had been no change. The risk assessments included risks specific to the person such as for falls and pressure area care. Choking risk assessments were not available to identify if people had specific risks associated with eating and drinking. Several call bells were not available for people to use whilst in their bedroom and individual risk assessments were not in place to document why they were not available when people no longer had capacity to use them safely. Detailed risk assessments and their evaluations were needed to ensure they remained relevant, reduced risk and to keep people safe.

Written guidance was not in place for the use of some "when required" medicines for people. There was no written guidance for staff that included when and how these medicines should be administered to ensure a consistent approach to the use of such medicines, such as for pain relief or for agitation and distress. Medicines records for some people stated, for example, "Artificial saliva two sprays to mouth when required," "Paracetamol when required," and, "Lorazepam half tablet when required for agitation."

Records showed there was minimal use of medicines to manage distressed behaviours but as there was no written guidance for its use staff were not provided with a consistent approach to the administration of such medicines. We saw care plans for distressed behaviour were in place however, they were vague and not detailed to give staff guidance about the actions that should be taken when the person became agitated and distressed. Written information did not show the staff interventions required. The care plan did not give staff detailed instructions with regard to supporting the person. This would help ensure staff all worked in a consistent way with the person to help reduce the anxiety and distressed behaviour. Staff we spoke with were aware of people's different behavioural needs and could recognise what may trigger someone's distress.

Neither risk assessments or care plans were in place to advise what staff should do if people refused to accept any assistance or refused to carry out their own personal care. Staff we spoke with could tell us they went back and asked the person again if they refused.

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

Medicines were given as prescribed. We observed a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. Systems were in place to ensure that all medicines had been ordered, stored securely, administered safely and audited.

Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the department of psychiatry of old age and the community mental health team. Staff told us they followed the instructions and guidance of the community mental health team for example to complete behavioural charts if a person displayed distressed behaviour. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known.

We had concerns about the standards of hygiene and infection control in some areas of the home.

Requires improvement

Is the service safe?

There were no appropriate storage facilities for toiletries in the en suite bathrooms as toiletries and tooth brushes were stored on the plinth next to the lavatory, continence aids such as boxes of pads were stored on the floor next to the lavatory. There was a malodour in some bedrooms and communal areas of the home, light switches were sticky and the top cover of the light switch was missing in some bedrooms. In some bedrooms we saw beds were not properly made up and pillow cases and the sheets in some bedrooms were stained. The table tops and surfaces in some areas were not properly cleaned. The registered manager told us this was being addressed and the health and safety audit carried out on the Monday before our inspection had identified the lack of storage in bathrooms.

People said they felt safe and they could speak to staff. Peoples' comments included, "I do feel safe here, staff are around if I need them," and, "Of course I feel safe." Relatives' comments included, "(Name) is very safe and I'm fully involved in (Name)'s care planning," "There are always staff around," "I think my relative is well looked after and very safe here." Staff members' comments included, "Yes, I think people are safe here. There have been times when people hit each other, however everything's documented and reported and closely monitored," and, "Yes, I feel safe working here, staff support each other."

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged appropriately by the registered manager.12 safeguarding alerts had been raised. They had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns. The information had been shared with other agencies for example, the local authority safeguarding team. One safeguarding was still under investigation by the service at the time of inspection.

Staff had an understanding of safeguarding and knew how to report any concerns. They were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. They told us they would report any concerns to the registered manager. Staff members' comments included, "I'd go to my manager first," "I've done safeguarding training to protect people and keep them safe," and, "I'd report any concerns to the nurse."

There were sufficient numbers of staff available to keep people safe. Staffing levels were determined by the number of people using the service and their needs. There were 74 people who were living at the home. Staffing rosters and observations showed on the Bamburgh unit 16 people were supported by three support workers including a senior support worker, on the Alnwick unit 29 people were supported by one nurse and six support workers. On the Lumley unit 29 people were supported by two or three nurses and ten support workers. Staff comments included, "I think there are enough staff," "We need this many staff to support some of the peoples' needs," "At the minute the staffing is good, we always have two-three qualified staff on this unit," "The manager always makes sure we have enough staff," "There are always six care staff on this unit," "If we need to use agency staff we stick with the same regular staff, people know them well," and, "We very rarely need to use agency staff, we only use them when we're short staffed."

Overnight staffing levels included from 8:00pm-8:00am one nurse, one senior support worker and six support workers. These numbers did not include the registered manager and unit managers who were also on duty each day.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

Requires improvement

Is the service safe?

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Good

Is the service effective?

Our findings

We checked to see how people's nutritional needs were met. We looked around the kitchen and saw it was well stocked with fresh, frozen and tinned produce. On the day of inspection the lunchtime meal was pasty and beans, beans on toast or sandwiches and soup as the main meal was in the evening. People's comments included, "The food is okay," "The food is good," and, "There's more than enough to eat."

Referrals were made to relevant health care professionals, such as, GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of a person's poor nutritional intake. We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. They told us they received verbal information from nursing staff when people required a specialised diet. We saw a colour coded board was available in the kitchen to show information and capture any changes that had been communicated about people's dietary requirements. The cook explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and they explained how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. Snacks were also available in communal areas for people to help themselves. These included snacks such as cheese, crisps, chocolate bars and biscuits to help increase the nutrition of people who were at risk of poor nutrition and weight loss. One relative commented, "The staff are getting to know (Name), and they've put some weight on which they needed."

The home was being refurbished and the environment was being designed to ensure it continued to be stimulating and therapeutic for the benefit of people who lived there. We saw there was a wealth of visual and sensory stimulation to help maintain the involvement and orientation of people with dementia. For example, one of the dining rooms was decorated and furnished as a 1950's themed 'diner,' a small lounge was decorated as a railway station waiting room, another room was set up as a shop from the Beamish Museum, a bar was available and furnished with optics and drinks and we observed two people having a drink and some crisps with relatives. The communal areas and hallways had decorations and pictures of interest, there were displays and themed areas around the home, for example, musical instruments, sports equipment. A corridor was lined with a display of local shops with their contents that used to be in the local area to stimulate and remind people as they sat or walked around. There was appropriate signage around the building to help maintain people's orientation. Lavatories and bathrooms had pictures and signs and bedroom doors were painted different bright colours for people to identify the room to help maintain their independence.

We found when looking around the environment that some further improvements were needed. We saw the tap indicators that showed the hot and cold tap were missing from several taps in en suite bathrooms. In one bedroom the drawer front was missing. Light bulbs were missing from two en suite bathrooms. The tea and coffee pots were stained and discoloured. The seal on the fridge on the Lumley unit was perished, the lid of the chest freezer in the main kitchen was broken. The dining room walls on the Lumley unit were marked. On the Lumley Unit the sideboard was showing signs of wear and tear and the corridor carpet was marked. Around the home several bedside lamps were out of reach of people if they wished to use a lamp whilst in bed. Some other corridor carpets were marked. The bedding available on some peoples' beds was worn as it was thin and limp. The registered manager told us some of the issues such as the carpets and the missing tap indicators were already being addressed. The carpets had been replaced in the last year and a new steam cleaner had been purchased to try to improve them. The registered manager told us that other issues would be addressed immediately.

The gardens were secure and well maintained. They were overlooked by many of the bedrooms and lounges. They accommodated rabbits, guinea pigs, chickens, bird feeders and animal garden ornaments which made the areas attractive and provided interest and stimulation for people who lived in the home. We were told some of the people were involved in caring for the animals and feeding them.

Staff told us and their training records showed they had opportunities for training to understand people's care and support needs and they were supported in their role. Staff comments included, "We've been having training every Tuesday for months," "The training is very good," "I've done more training here in six months than I did in a year and a half at my last job," "We get lots of training and it's really

Good

Is the service effective?

good," "There are loads of training opportunities," "We get trained on everything," "I've done end of life care, dementia care, person centred care and defibrillator training," and, "My next training is about the Mental Capacity Act."

We spoke with members of staff who were able to describe their role and responsibilities clearly. Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. Staff members comments included, "When I first started I was not on shift by myself until I knew what I was doing," and, "I had a twelve week induction when I started."

The staff training records showed staff were kept up-to-date with safe working practices. The manager told us there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Training courses included, dementia care, distressed behaviour, nutrition and hydration, dignity awareness, person centred care, equality and diversity. 'meaningful' activities, breakaway techniques and basic life support.

Staff were supported in their role. Support staff said they received regular supervision from one of the home's management team every two months and nurses received supervision from the registered manager. Staff comments included, "I have supervision every two months," "I get feedback about how I'm doing at work," "I have supervision with the nurse in charge," and, "I've just had supervision recently." Staff also received an annual appraisal to evaluate their work performance and to jointly identify any personal development and training needs.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Philips Court records showed 65 people were legally authorised and two applications were waiting for assessment by the local authority.

Records showed assessments had been carried out, where necessary of people's capacity to make particular decisions. For example an assessment stated, "(Name) is able to make complex decisions but when it comes to eating they make poor decisions."

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. We were told a monthly clinic was held at the home that was run by the psychiatrist, General Practitioner and specialist nurse for older people. People's relatives were also invited to attend people's appointments to keep them up to date with people's health and well-being. The clinic was held to review people's mental health needs and any acute health needs to make sure they were treated promptly. A relative commented, "(Name) has a problem with sores on their feet, and the nurses seem to be taking good care of them for (Name).

Staff received advice and guidance when needed from specialists such as, the community nurse, dietician, speech and language teams, psychiatrist and GPs. Records were kept of visits and any changes and advice was reflected in people's care plans. Comments from health care professionals we contacted before the inspection included, "Philips Court provides excellent care for people who live with dementia," "The best home in the borough for dementia care in my view," "Able to manage residents that other settings can't," "Very good skills around complex mental health needs," and, "The staff manage some very challenging residents and will tap into other services for advice when needed."

People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so that staff were aware of the current state of health and well-being of people. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. The nurses told us a handover of verbal and written information took place between the staff for each shift. All staff were involved in the handover. Staff members comments included, "The handover is good, it lasts as long as it needs to, if I haven't been in for the week

Good

Is the service effective?

I'd be told everything that had happened in the last week," "Handover sheets don't tell you everything, we go through the sheet, it lasts about half an hour and I involve staff to tell me what's happening." Other staff commented, "Communication is effective," "Communication is very good and we're kept informed about how people are and if there have been any changes."

Good

Is the service caring?

Our findings

People who used the service and relatives we spoke with were very positive about the care and support provided. People's comments included, "I like living here, I'm well looked after," "The staff are excellent," "Staff are kind they really care, they'll give you a cuddle if you feel down," "Staff's patience is endless," and, "They do a good job." Relatives' comments included, "It's a lovely happy atmosphere," "There have been no changes in staff and that is good for continuity of care which gives (Name) confidence," "I couldn't ask for more the care is good," and, "I'm very happy with the way they look after (Name)." A health professional commented, "The staff demonstrate that they are very caring towards the residents and demonstrate good skills in communicating with them."

People were supported by staff who were warm, kind, caring, considerate and respectful. Staff engaged with people in a calm and quiet way. They bent down when they carried out tasks with the person and as they talked to people so they were at eye level. They asked the person's permission before they carried out any intervention. For example, "Can I help you get your drink.?"

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. Relative's told us staff seemed knowledgeable about people's care needs and knew how to look after them. Their comments included, ""The carers all know (Name) well and (Name) has improved since they have come here," "(Name) was angry before, but since they have come here two weeks ago they have settled down."

Staff described how they supported people who did not express their views verbally. Staff observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. Staff member comments included, "We use picture aids for some people and some people can verbalise to tell us," "You get to know by facial gestures," "You can also tell by someone's posture if they are in pain," and, "We've done training about communicating with people with dementia." Staff also gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing and two plates of food. This encouraged the person to maintain some involvement and control in their care. A person's care plan stated, "(Name) can choose their own clothes but the assistance of two staff is required."

We observed the lunch time meals on all floors of the home. The dining experience was not well organised on all floors. In all areas it was busy but calm. We saw staff wore protective clothing and tested the temperature of food in the hot trolley before serving it. On the ground floor in one dining room some of the tablecloths and placemats still showed the remnants of breakfast. The tables were not set with cutlery, condiments and napkins before people came for their meal. A support worker arrived with knives and forks as the meals were served. Some people tried to eat their soup and pudding with forks as they did not have a spoon. Juice and water was not available with the meal, we saw people were offered a hot drink after the meal. Menus were not available and we asked one person what was for lunch, they commented, "I don't know, they don't tell you." Staff provided full assistance or prompts to people to encourage them to eat, and they did this in a quiet, gentle way. For example, we heard staff say "Would you like me to cut your pasty," "Can I help you with your lunch." People were offered a choice and one person said they wanted both meal options and this was given to them. People who had ordered sandwiches however were not offered a choice of bread or filling. We discussed this with the registered manager and they told us this would be addressed.

In other areas of the home we saw people were supported to eat at their own pace and if they chose not to sit and eat in the dining room staff supported them holding their food as they walked around encouraging them to eat some finger foods.

Important information about people's future care was stored prominently within their care records, for instance where people had made Advance Decisions about their future care. Records looked at, where these were in place, showed the relevant people were involved in these decisions about a person's end of life care choices. The care plan detailed the "do not attempt resuscitation" (DNAR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

Good

Is the service caring?

We were told the service used advocates as required but most people had relatives. Advocates can represent the views for people who are not able to express their wishes.

Requires improvement

Is the service responsive?

Our findings

We had concerns that records did not accurately reflect the care that people received and record keeping was not consistent.

Records showed people's needs were assessed before they moved into the home to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort.

Records showed continence assessments were not available for all the people who required them and the information had not been transferred into care plans that detailed the recommended incontinence products a person should use. Pain assessments were not available for all people to record people's pain tolerance and how they may show they were in pain if they were no longer able to communicate this verbally.

We had concerns the charts to monitor peoples' nutrition and hydration were not always accurately completed.

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised tool Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss. Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid balance' charts. However, an accurate record was not always maintained to monitor the amount of food and drink the person had taken. The food charts used to record the amount of food a person was taking each day did not accurately document the amount of food a person consumed. Fluid intake charts did not record the goals and there was inconsistent completion of the totals recorded.

Pressure area assessments had been carried out which showed if people were at risk of developing pressure damage to their skin. Care plans had been created from these assessments where required, but care plans did not record in detail people's current care and support needs and how the treatment was to be provided. For example, two records showed people did have pressure area damage but there was incomplete documentation in relation to the recording of skin evaluation, pain and infection. A body map was not completed to show the site of the wound, the dimensions of the wound, odour and redness were not recorded, a wound photograph was not available. For one of the wounds we were shown a photograph that was taken on the day of inspection. There were limited instructions written in the care plans regarding wound care and associated treatment and dressings. For example, a record stated, "Change dressing as required following assessment of wound, report deterioration to the tissue viability nurse." We saw that a referral to the tissue viability nurse had been made and they were due to visit imminently. Pressure relieving equipment was available for people as required. For example, a care plan stated, "Airflow mattress to assist in skin integrity, staff are to reposition me on a two hourly basis."

Staff knew the individual care and support needs of people, as they provided the day to day support. Care plans did not provide details for staff about how the person's care needs were to be met. They did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They did not detail what the person was able to do to take part in their care and to maintain some independence. For example, ""(Name) needs assistance of two members of staff for all personal hygiene and dressing needs," "(Name) is unable to mobilise independently. They require the assistance of two staff members using the hoist for all transfers," and, "(Name) can assist themselves with help from one member of staff." We were told moving and assisting care plans were being supplemented with standardised generalised moving and assisting information. However, it was not person centred as it did not contain specific details about the different interventions required by staff for each person as people had different needs and wishes.

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in people's needs. For example, the dietician was asked for advice with regard to nutrition. This information was usually then transferred to peoples' support plans which we were told were up-dated monthly. However, not all records we looked at were up to date. For example, one person's records showed they had been referred to the dietician but the outcome of the visit had not been recorded in the daily diary that staff completed for each person. The daily dairy was used to record the person's daily routine and progress in order to

Is the service responsive?

monitor their health and well-being. This was necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

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

Information was available to help staff provide care and support when a person was no longer able to tell staff themselves how they wanted to be cared for. Detailed information was available for each person in the form of a life history and a record of their likes and dislikes, which had been collected from relatives. This gave staff some insight into people's previous interests and hobbies when people could no longer communicate this information themselves. People's care plans also provided information about their social interests. For example, "I like to play ball games, throwing and catching," and, "I really like to play pool."

People confirmed they had a choice about getting involved in activities. Relatives' comments included, "The home organise some very good activities, including regular outside entertainment," and, "(Name) has been out on the minibus to church." We saw a 'day room' was available on the ground floor of the home where people came from other areas of the home supported by staff for activities. We saw it was a bustling, interesting environment for people and staff supported by the activities person carried out some individual and group activities throughout the day. Staff spent time interacting with people engaging in conversation, hand massage, dominoes and whatever the person responded to. Sensory stimulation also took place with people using smelling oils, beading and drawing was also available to supplement the other activities. Other activities that took place on a regular basis included, bingo, armchair exercises, dominoes, jigsaws, card games, pamper sessions, quizzes, games, baking, animal tending and garden activities. We were told when the activities person was not on duty support staff carried out activities. People were supported by staff to go out individually and in groups into the community. The home had access to a minibus and resident meeting minutes showed people had been to the coast, to Beamish and on other local trips when the weather was good.

Regular meetings were held with people who used the service and their relatives. The manager said meetings provided feedback from people about the running of the home. Meeting minutes showed topics included updates about the refurbishment that was taking place in the home, staffing levels, activities planned such as the crazy golf course and some new animals, mini pigs to add to the livestock. We saw the meetings were also an opportunity for people to give feedback about the care they received. The cook also attended the meetings to get comments about the food and suggestions for the menus.

People said they knew how to complain. The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained and we saw seven had been received, investigated and resolved. We spoke to one relative about some concerns they had and we were told by the registered manager they were aware of the concerns and they were being investigated. Other relatives commented, "I haven't needed to complain," "I have no complaints, I think (Name) is well looked after," and, "You always have a few niggles but these are put right as soon as I mention them."

Requires improvement

Is the service well-led?

Our findings

A registered manager was in post and they had registered with the Care Quality Commission in August 2013. The registered manager understood their role and responsibilities to ensure notifiable incidents such as safeguarding and serious injuries were reported to the appropriate authorities.

We had concerns the audit and governance processes had failed to identify deficits in certain aspects of record keeping.

Records showed audits were carried out regularly and updated as required. Monthly audits included checks on medicines management, care documentation, training, hand hygiene, infection control, kitchen audits, accidents and incidents, clinical governance and nutrition. Six monthly audits were also carried out for health and safety. Although records were audited monthly and included checks on care documentation, these audits had not highlighted deficits in certain aspects of record keeping such as risk assessments and care planning to ensure people's care records contained detailed guidance so people received safe care in the way they wanted and needed.

The registered manager told us if any issues were identified in the monthly audit the frequency would be increased to weekly until improvements had been made. We were told monthly visits were carried out by a representative from head office to speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans, complaints, accidents and incidents, nutrition and hydration, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. An annual audit was also carried out by the organisation which awarded the home an internal rating which reflected any risks in the running of the service. We saw the results of the audit that had taken place in May 2015. An annual external audit of finances was also carried out by a representative from head office.

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

The atmosphere in the home was bustling, vibrant and friendly. People moved around different areas and sat and watched the comings and goings around the home. People who could tell us spoke with enthusiasm and pride about the garden and outside environment they had helped to create.

The registered manager promoted an ethos of involvement and empowerment to keep people who used the service involved in their daily lives and daily decision making. Staff and relatives were also involved and encouraged to give ideas about the running of the home. The registered manager was passionate and enthusiastic about ensuring people who lived with dementia were encouraged to lead a fulfilled life whatever their level of need. We saw the results of the provider's survey from March 2015, which had been completed by relatives and people who used the service. This showed there had been a 100 percent response stating that people were encouraged to join in activities. The registered manager was pro-active in securing funding from different agencies such as the lottery fund to ensure that people should experience a stimulating and therapeutic environment. Meeting minutes showed they had been successful in securing additional funding for activities for people. A committee had been formed by relatives and people from the home to oversee the spending of the fund on suitable activities and pastimes and to secure more funding for activities. Staff worked as a team and there was a sense of pride and fulfilment in their work. We observed that people who used the service knew the manager and related well to them.

The home was progressive and the manager was pro-active in ensuring that staff were kept up to date with developments in the care of people who live with dementia or a dementia related condition.

Staff meeting minutes showed the manager was keeping staff up to date with recent dementia care research. For example, with regard to dementia and learning, the manager was approaching a local college to see if tutoring could be arranged at the home for people who might be interested in keeping their minds active after dementia had been diagnosed. The manager was also keen to obtain technology to help people to utilise computers and was working with Newcastle University on a dementia robot system. The manager also kept up to date with the latest research and information on environmental design from Salford University.

Requires improvement

Is the service well-led?

The home was successful in internal competitions and had won internal awards because of the care provided to people. A support worker was in the finals of a national care award competition. The manager and staff team had won an equality and diversity award from Gateshead council in recognition of their support of people who lived with dementia.

Staff said they felt well-supported and the manager was approachable. Comments from staff included, "I love working here," "It's pleasant and a lively environment to work in," "I think the quality of care at the service is good and the manager is very firm but I think that is good so standards don't slip," "It's a difficult home but the support from the manager is second to none and we have a good team," "We're a strong team," "No staff have left since I started," "We have very good staff retention only a couple of staff have left," and, "The manager is very approachable."

Relatives' comments included, "The home never hide anything, they are very open, "Management are very supportive," "The home has a good outlook on dementia care," "The home seems to be well-managed and the manager is very approachable," and, "The manager has an open-door policy and is always around. (Name) is full of enthusiasm. Staff appear to get on well with them." Professionals we contacted before the inspection commented, "Overall the home seems to be well-led, the manager is very knowledgeable about dementia and mental health issues, they're always available," "There's strong leadership and good staff retention."

Records showed audits were carried out regularly and updated as required. Monthly audits included checks on medicines management, care documentation, training, hand hygiene, infection control, kitchen audits, accidents and incidents, clinical governance and nutrition. Six monthly audits were also carried out for health and safety. The registered manager told us if any issues were identified in the monthly audit the frequency would be increased to weekly until improvements had been made. We were told monthly visits were carried out by a representative from head office to speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans, complaints, accidents and incidents, nutrition and hydration, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. An annual audit was also carried out by the organisation which awarded the home an internal rating which reflected any risks in the running of the service. We saw the results of the audit that had taken place in May 2015. An annual external audit of finances was also carried out by a representative from head office.

Regular analysis of incidents and accidents took place. The registered manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re-occurrence. Records showed where a person had fallen more than twice they were referred to the falls clinic. The registered manager told us if an incident occurred it was discussed at a staff meeting. Reflective practice took place with staff to look at 'lessons learned' to reduce the likelihood of the same incident being repeated. A staff member commented, "Any incidents or accidents are handed over on an individual basis, if there are any issues we'd discuss them with the manager and how to fix them."

Staff told us regular staff meetings took place and these included nurses' meetings and general staff meetings. Staff meetings kept staff updated with any changes in the home and to discuss any issues and developments.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out six monthly to staff and people who used the service. We were told surveys had just been sent out. We saw results from a survey that had been completed by people who used the service and relatives in March 2015. We were told the results were analysed by head office and information sent to the registered manager so that action could be taken as a result of people's comments, to improve the quality of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

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 The registered person had not ensured systems and processes were established and operated to ensure compliance with the registered persons need to: assess, monitor and improve the quality and safety of the service; assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk, maintain an accurate, complete and contemporaneous record for each person; evaluate and improve their practice. Regulation 17 (2)(a)(b)(c)(f)