Gainford Care Homes Limited

Lindisfarne Seaham

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 21 and 24 March 2016 and was unannounced. This meant the staff and provider did not know we would be visiting.

Lindisfarne Seaham provides care and accommodation for up to 62 people who require nursing or personal care, some of whom have a dementia type illness. On the day of our inspection there were 48 people using the service.

The home had 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 2008 and associated Regulations about how the service is run.

Lindisfarne Seaham was last inspected by CQC on 7 August 2015 and was compliant with the regulations in force at that time.

Accidents and incidents were appropriately recorded and investigated. Checks were carried out to ensure that people who used the service were in a safe environment and the home was clean, spacious and suitable for the people who used the service.

The provider understood the safeguarding procedures and had followed them, and staff had been trained in safeguarding vulnerable adults.

Medicines were stored safely and securely, and procedures were in place to ensure people received medicines as prescribed.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. Staff were suitably trained and training sessions were planned for any due or overdue refresher training. Staff received regular supervisions and appraisals.

The provider was working within the principles of the Mental Capacity Act and was following the requirements in the Deprivation of Liberty Safeguards.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of visits to and from external health care specialists.

People who used the service, and family members, were complimentary about the standard of care at Lindisfarne Seaham. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Care records showed that people's needs were assessed before they moved into Lindisfarne Seaham and care plans were written in a person centred way.

Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs.

People who used the service, and family members, were aware of how to make a complaint and the provider had an appropriate complaints process in place.

Staff felt supported by the management team and were comfortable raising any concerns. People who used the service, family members and staff were regularly consulted about the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were appropriate to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and investigated.

Appropriate safeguarding procedures were in place and staff had been trained in safeguarding vulnerable adults.

People were protected against the risks associated with the unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

Staff were aware of people's nutritional needs and what action to take.

People had access to healthcare services and received ongoing healthcare support.

The provider was working within the principles of the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and independence was promoted.

People were well presented and staff talked with people in a polite and respectful manner.

People had been involved in writing their care plans and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they moved into Lindisfarne Seaham and care plans were written in a person centred way.

The home had a full programme of activities in place for people who used the service.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well led.

The service had a positive culture that was person-centred, open and inclusive.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff told us they felt supported in their role.

Lindisfarne Seaham

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 21 and 24 March 2016 and was unannounced. This meant the staff and provider did not know we would be visiting. One Adult Social Care inspector and a specialist advisor in nursing took part in this inspection.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. No concerns had been raised. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. No concerns were raised by any of these professionals.

During our inspection we spoke with five people who used the service and four family members. We also spoke with the regional manager, area support manager, quality facilitator, administrator, one nurse, seven care staff and one domestic staff member.

We looked at the personal care or treatment records of eight people who used the service and observed how people were being cared for. We also looked at the personnel files for four members of staff and records relating to the management of the service, such as quality audits, policies and procedures. We also carried out observations of people and their interactions with staff.

Good

Is the service safe?

Our findings

Family members we spoke with told us they thought their relatives were safe at Lindisfarne Seaham. They told us, "Very safe" and "She's safer here".

We looked at the recruitment records for four members of staff and saw that appropriate checks had been undertaken before staff began working at the home. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults.

Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We discussed staffing levels with the regional manager and looked at staff rotas. Staffing levels for the home included two nurses and at least eight care staff on duty during the day, and one nurse and at least five care staff on duty during the night. Staff rotas we looked at showed these staffing levels were often exceeded. The regional manager told us they did not use agency staff very often but had done recently to cover staff holidays. Staff we spoke with did not raise any concerns regarding staffing levels

We looked at the staff allocation files. These showed which members of staff were on duty on each floor and included a list of tasks the staff had to carry out. For example, check medicine administration records, tidy the fridge and night time cleaning duties.

The home is a detached, three storey building in its own grounds. Entry to the premises was via a locked door and all visitors were required to sign in. The home was clean, spacious and suitable for the people who used the service. Appropriate personal protective equipment (PPE), hand hygiene signs and liquid soap were in place and available. We did however notice an odour from the carpet on the middle floor and the boxed in area behind a toilet on the first floor was in need of attention as the paint had peeled off, exposing the bare wood. We discussed these with the regional manager who told us they were aware of the issues and plans were in place to replace the carpet and repair the boxed area in the toilet. People and their family members we spoke with were complimentary about the home and no negative comments were received.

Hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014.

Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date. Risks to people's safety in the event of a fire had been identified and managed, for example, a recent fire service inspection had taken place, fire alarm and emergency lighting tests took place regularly and emergency evacuation plans were in place for each person who used the service.

In the bedrooms we looked in, window restrictors were in place and wardrobes were secured to walls to prevent any from falling over. A monthly health and safety inspection was carried out, which included checks of housekeeping, equipment and machinery, personal protective equipment (PPE), fire safety and emergency evacuation, chemicals and other hazardous materials, security, vehicles and food hygiene. Action plans were in place for any identified issues. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

A risk monitoring report was completed weekly. This checked whether people had any serious changes in their health status, such as pressure damage or significant weight variance, and recorded what action had been taken.

The provider's safeguarding file included relevant guidance on protecting vulnerable people and a copy of the local authority risk threshold tool. The safeguarding log recorded every safeguarding incident that had occurred at the home. Individual forms were completed, which included details of the incident, who was involved, what action was taken and the outcome. Following each safeguarding incident, a 'Lessons learned' form was completed, which recorded the measures that were put in place, who discussions had taken place with and whether the appropriate notifications had been submitted. This meant the provider understood the safeguarding procedures and had followed them.

Accidents and incidents were recorded on the provider's electronic system and analysis was carried out on a monthly basis to identify any trends. For example, it was identified from accidents and incidents in February 2016 that the majority of falls had occurred in people's own bedrooms. One person had fallen three times and appropriate actions had taken place such as, a motion sensor was put in place in the person's bedroom and the person had been referred to the falls team.

We looked at the way medicines were managed. Systems were in place to ensure that medicines had been ordered, stored and administered appropriately. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed.

The nurse checked people's medicines on the medicines administration record (MAR) and medicine label, prior to supporting people to take them. Medicines were given from the container they were supplied in and we observed the nurse explain to people what medicine they were taking and why. People were given the support and time they needed when taking their medicines. People were offered a drink of water and the nurse checked that all medicines were taken. The MARs showed that staff recorded when people received their medicines and entries had been initialled by staff to show that they had been administered. Appropriate codes had been entered on the MAR chart, however we saw that some MARs did not have an area on the back of the MAR record to provide further explanation, for example, for the administration of PRN medicines (PRN is medicine that is given as required).

We reviewed a sample of MAR sheets and found overall, MARs were correctly completed, apart from three gaps in one person's MAR on 9 March 2016, where entries were not initialled by staff as confirmation of the medicines being administered. The area support manager reassured us that they would be implementing a 'Daily MAR sheet audit' forthwith to ensure that all MAR charts were checked at the end of a shift, to ensure MARs were correctly completed and there were no missing signatures.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

We were told that three people received their medicines covertly. The covert administration of medicines occurs when a medicine is administered in a disguised format without the knowledge or the consent of the person, for example, mixed with food or drink. There was a letter from the person's General Practitioner (GP) authorising the administration method and a best interest meeting with the GP, care home staff, social worker, pharmacist and family member had taken place.

Medicines which required cool storage were stored appropriately in a fridge which was within a locked room. Medicines with a short life once opened had the date of opening noted, this meant they remained safe and effective to use. Minimum and maximum temperatures were recorded daily and were between two and eight degrees centigrade however current temperatures relating to refrigeration had not been recorded. When we discussed this with the area support manager they told us they would implement the new fridge temperature sheet that recorded current, maximum and minimum recordings. Temperatures for the treatment room were recorded daily and were less than 25 degrees centigrade. Fridge and treatment room temperatures need to be recorded to make sure medicines were stored within the recommended temperature ranges. This meant that the quality of medicines was not compromised, as they had been stored under required conditions.

The most recent monthly medicines audit had been carried out in February 2016 and an action plan was in place for any identified issues. The quality facilitator told us they would review whether the actions had been carried out when the next monthly audit took place.

This meant appropriate arrangements were in place for the administration and storage of medicines.

Good

Is the service effective?

Our findings

People who lived at Lindisfarne Seaham received effective care and support from well trained and well supported staff. People and family members told us, "It's very nice", "I'm well looked after", "She's well looked after", "It's lovely" and "Lovely girls".

We looked at staff training records and saw annual training included moving and handling, safe handling of medicines, infection control, health and safety, safeguarding and whistleblowing and first aid. Staff also received training in mental capacity, fire safety, food hygiene, control of substances hazardous to health (COSHH), behaviour that challenges and dementia. The majority of the training was up to date and where there were any gaps, we saw the training was planned.

Records showed that staff received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace.

New staff completed an induction to the service, which included an introduction to the service, policies and procedures, and mandatory training. All new staff were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training for new staff working in health and social care.

People had access to a choice of food and drink throughout the day and we saw staff supporting people in the dining rooms at meal times when required. People were supported to eat in their own bedrooms if they preferred. In the kitchen we saw copies of people's care plans, speech and language team (SALT) recommendations and diet notification sheets. Kitchen and care staff we spoke with were aware of these records and knowledgeable about people's dietary needs. Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs. Choking risk assessments were completed to identify if people were at specific risk of eating and drinking and whether referrals should be made to external professionals. This meant staff were aware of people's nutritional needs and what action to take.

We looked at the nutrition audit carried out in February 2016. This audit carried out checks on the dining experience, whether daily menus reflected what was being served, people's individual dietary needs and that staff were aware, whether people were offered a choice of food and drink and whether care records and charts were accurate and up to date.

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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We discussed DoLS with the area support manager and saw records of DoLS applications to the local authority. Notifications of the applications that had been authorised had been submitted to CQC. This meant the provider was following the requirements in the DoLS.

Mental capacity assessments had been completed for people and best interest decisions made for their care and treatment. Staff had completed training in the MCA and DoLS. Mental capacity audits took place and included a check of documentation to ensure care plans were up to date, DoLS applications had been made where necessary and that for each complex decision, there was evidence that a mental capacity assessment had been carried out and best interest decision had been made.

Care records included Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). These were up to date, the correct form had been used and included an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

Communication care plans were in place and were appropriate for the person. We saw specific information for staff to follow in relation to how they engaged with people, for example, by using communication cards provided by the speech and language therapy team (SALT). This approach meant staff provided responsive care, recognising that people living with communication needs could still be engaged in decision making and interaction.

People's care records showed details of appointments with, and visits by, health and social care professionals. Staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. For example, General Practitioners (GPs), SALT and advanced nurse practitioners. Care plans reflected the advice and guidance provided by external health and social care professionals. This demonstrated that staff worked with various healthcare and social care agencies and sought professional advice, to ensure that the individual needs of the people were being met.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home. Carpets were clean, not patterned and contrasted clearly with walls. Likewise, hand rails contrasted with the walls and communal spaces and bathrooms were spacious and free from clutter. Toilets and bathroom doors were clearly marked and memory boxes were on walls outside people's bedrooms for those who wanted them. Dementia friendly displays were on corridor walls and were themed based on the interests of the people who lived on the corridor, for example, football, war memorabilia and famous actors and musicians. This meant the service incorporated environmental aspects that were dementia friendly.

Good

Is the service caring?

Our findings

People who used the service, and family members, were complimentary about the standard of care at Lindisfarne Seaham. Family members told us, "The staff are fantastic. One girl looks after her like it's her own mother" and "She definitely gets the care she needs".

Staff promoted people's independence. For example, we observed staff escorting people to the dining room for lunch. This was done in a patient and unhurried manner. Staff encouraged people to mobilise independently or with walking aids. Staff told people, "We will support you. We won't let you fall" and "I'm right behind you. Don't worry". After lunch, people were asked if they were ready to go back to the lounge and those people who were able to were asked to push their chairs out and stand independently. This meant that staff supported people to be independent and people were encouraged to care for themselves where possible.

People we saw were well presented and looked comfortable with staff. We saw staff talking to people in a polite and respectful manner and staff interacted with people at every opportunity. For example, we observed staff interacting with people in the ground floor lounge. People and staff were laughing and playing games. When staff carried out tasks for people they bent down as they talked to them, so they were at eye level. Staff explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner.

During lunch we observed staff talking to people and offering choices. Staff asked people what they wanted to eat and drink, for example, "Would you like stuffing with your chicken?" and "Would you like gravy with that?" Staff talked to people about what they were going to do after lunch. For example, "This afternoon I'm going to paint your nails. We'll have a pamper session ladies." The staff member offered people a choice and said, "That's if you want them painted. You don't have to."

During our inspection visit we observed staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. Care records included information on how people wanted to be supported with their personal care. For example, "[Name] would like their hair brushed and nails cleaned daily." One person had a sign on their bedroom door which stated, "[Name]'s TV time. Do not disturb." Staff we spoke with were aware of this. We observed staff asking people if they wanted to go to the bathroom. This was done in a discreet manner. Staff we spoke with told us people's dignity was important. One staff member told us, "It's their home." We asked people and family members whether staff respected the dignity and privacy of people who used the service. They told us, "Yes, absolutely." This meant that staff treated people with dignity and respect.

Bedrooms were individualised, some with people's own furniture and personal possessions. We saw many photographs of relatives and occasions in people's bedrooms. All the people we spoke with told us they could have visitors whenever they wished. Family members we spoke with told us they could visit at any time and were always made welcome.

We saw in the care records that end of life care plans were in place for people, which meant information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected.

Good

Is the service responsive?

Our findings

The service was responsive. We saw that care records were regularly reviewed and evaluated.

All the care records we looked at contained a pre-admission assessment to assess people's needs before they moved into the home. This ensured that staff could meet people's needs and that the home had the necessary equipment to ensure the person's safety and comfort. Following an initial assessment, care plans were developed detailing the person's care needs to ensure personalised care was provided to all people. The initial assessment was also signed by the person who used the service. The care plans guided the work of care staff and were used as a basis for quality, continuity of care and risk management.

Assessments had been carried out to identify which people were at risk of developing pressure ulcers and preventative pressure relieving measures were in place for those people who required them. We found that people's care records were up to date apart from one person's Braden risk assessment had been updated on 9 October 2015 and subsequently on 6 March 2016. The Braden risk assessment is a tool that can identify those individuals at greatest risk for developing pressure ulcers. We saw a record on the person's care plan that stated, "Staff to update braden scale monthly."

People's mobility needs were identified and specific plans for supporting people with their mobility needs and transfers were in place and regularly reviewed. However, for one person their plan had been updated on 9 October 2015 and subsequently on 6 March 2016.

Care plans were reviewed monthly and on a more regular basis, in line with any changing needs, and were reflective of the care being given and reflective of change. However, for one person we saw that their care plans had been reviewed on 9 October 2015 and then again on 6 March 2016.
We discussed the identified gaps in the reviews of the person's records and assessments with the area support manager and quality facilitator, who told us they were aware of the issues as part of the service's action plan and were in the process of making the required improvements.

Daily notes were kept for each person, which were concise and information was recorded regarding basic care, hygiene, continence, mobility and nutrition. This was necessary to ensure staff had information that was accurate so people could be supported in line with their up to date needs and preferences.

Handover records showed that people's needs, daily care, treatment and professional interventions were communicated when staff changed duty at the beginning and end of each shift.

Activities took place at Lindisfarne Seaham on a regular basis. We saw a copy of the weekly activities list, which included daily activities that took place at the home each morning and afternoon. These included music therapy, creative pastimes, exercises, pampering sessions, games and movies. External activities also took place and people were encouraged to take part in activities based on their own choice and individual needs. This meant the provider protected people from social isolation.

The provider had a complaints policy and procedure in place and an easy to read version of the procedure was displayed in the entrance to the home. This provided information of the procedure to be followed when making a complaint. Complaints records showed there had been three formal complaints recorded at the home in the previous 12 months. Each record included details of the complaint and copies of letters sent to the complainant in response.

People, and their family members, we spoke with were aware of the complaints policy. Family members told us, "No complaints." This showed the provider had an effective complaints policy and procedure in place.

Good

Is the service well-led?

Our findings

The home had a registered manager in place however the registered manager was on sick leave at the time of our inspection visit. A registered manager is a person who has registered with CQC to manage the service. The service was being managed by staff from the provider's senior management team, who assisted us with our inspection.

Staff we spoke with felt supported by the management and told us they were comfortable raising any concerns. Staff told us, "I love it", "It's wonderful" and "Lots of support".

Staff were regularly consulted and kept up to date with information about the home and the provider. We saw records of staff meetings, the most recent had taken place in January 2016. 13 members of staff were in attendance at the meeting and discussions had taken place on training, infection control, audits, uniform policy, safeguarding, key workers, supervisions, meal times, activities, occupancy and laundry. A staff survey had taken place in 2015 and 10 responses had been received. This included questions on the level of staff satisfaction, teamwork, quality of care, training, communication and support.

We looked at what the provider did to check the quality of the service, and to seek people's views about it. We saw records of the provider's monthly home visit, which were carried out by the regional manager. These included a check of medicines, regulations, care documentation, management, health and safety, staffing, safeguarding, finance and environment. Action plans were in place for any identified issues.

A daily walkabout was completed and included a 10 point checklist. This included observations on the home and cleanliness, whether people appeared well cared for, whether staff were engaging positively with people, whether records were correct and up to date, feedback from people and staff and general observations on the atmosphere in the home. Any issues were recorded in an action plan. For example, on 15 March 2016, the tables had not been set for breakfast, and on 17 March 2016, some charts had not been completed accurately.

Other audits completed at the service included infection control, dining experience, admission records, medicines, care documentation, mattresses, equipment, kitchen and nutrition, and DNACPR records. All of these audits were up to date.

We saw records that showed that residents' and family meetings were planned however there had been no attendees at the most recent meeting in February 2016. The regional manager told us they had tried staggering the times however they still had no attendees at the meeting so were looking at alternative ways to improve attendance.

We saw an annual 'Relatives' survey' took place. The most recent in 2015 had received 10 responses. The survey asked questions regarding staff, activities, communication, leadership, support and improvements. The responses to the survey were mostly positive, for example, an excellent or good response.

Service review cards were available in the entrance foyer for people and visitors to complete and provide feedback on the quality of the service. A 'Questionnaire, suggestions and comments feedback' board was on the wall in the entrance foyer and provided a response from the provider on feedback received from the survey. For example, feedback had been received that people and visitors were generally satisfied with the service but activities, maintenance and communication could be improved. The provider's response stated that an activities rota had been formulated to ensure people on all units of the home had an activities plan they could see for the week and notices were displayed around the home for forthcoming events. We saw evidence of these. The provider also stated a new maintenance member of staff was to be appointed and the registered manager was to hold a monthly surgery in addition to their open door policy. The regional manager confirmed this.

This demonstrated that the provider gathered information about the quality of their service from a variety of sources.