Akari Care Limited

Wellburn House

Inspection report

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Ratings

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

Overall summary

The inspection visit took place on the 15 July 2015 and was unannounced which meant the staff and provider did not know we were visiting.

We last inspected the service on 21 February 2014 and found the service was compliant with regulations at that time.

There was an acting manager who had worked at the service for several years as a carer and had been acting manager since April 2015, they had not applied to CQC to become the registered manager . The home has now been operating without a registered manager for at least six months. 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. Not having a registered manager is a breach of the provider's conditions of registration and we will be dealing with this matter outside of the inspection process.

We found that safe recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. This included obtaining references from previous employers to show staff employed were safe to work with vulnerable people.

People told us they felt safe at the service and staff were aware of safeguarding procedures and told us what they

Summary of findings

would do to report a concern. We saw staffing numbers at the service was not always provided at the level of their own dependency tool, although people did not raise any concerns over staffing levels and staff provided prompt attention to people on the day of our visit.

There were issues with cleanliness and maintenance of the service in certain areas mainly toilets and bathrooms.

There were concerns around how staff managed the medicines. The service used a multi dose system where the pharmacy provided a photograph of each medicine in the blister pot. Some photographs did not match which medicines were dispensed into the blister pot. Some quantities were incorrect and did not match what had been carried over and administered. Medicines were not always administered correctly in line with the manufacturer's guidelines.

Staff did not have an understanding of the Mental Capacity Act 2005 and Deprivations of Liberties (DoLS) and were unsure of their responsibilities. People who had capacity had been put forward for authorisations incorrectly. Staff adopted restrictive practices for people irrespective of whether the person had capacity to make choice and even when DoLS had not been authorised still prevented people from leaving the home. Staff were not adhering to the requirements of the Mental Capacity Act 2005 code of practice. They presumed people lacked capacity and failed to complete capacity assessments prior to making decisions on behalf of people. There was also no evidence to show that when people did lack capacity decisions were made via the 'best interest' process.

There was not a regular programme of staff supervision or appraisal although the management team said these had now begun to take place. However the manager was not taking appropriate action to ensure staff received adequate supervision and when concerns arose such as complaints that staff were sleeping on duty or staff behaviour was not in line with expected practice this was not investigated. Staff training was in place and there was a matrix to monitor when mandatory training was due.

Care plans were slightly confusing in terms of format as the service was transitioning to a new format. People's basic needs and information about them were recorded but people's involvements in their reviews were not apparent. We found that risks were not always appropriately assessed and action was not taken to reduce the impact of potential risks.

We saw people being given choices and encouraged to take part in all aspects of day to day life at the service. The service encouraged people to maintain their independence and provided a variety of activities and people told us they were treated with dignity and respect.

We observed a lunchtime and teatime meal. People were not well supported to have their nutritional needs met and mealtimes were not always well supported. Several people said the food was only warm not hot.

Accidents and incidents were not adequately monitored by the service to ensure any trends were identified. We saw patterns of incidents at night time that had not been addressed.

We saw safety checks and certificates that were all within the last twelve months for items that had been serviced and checked such as fire equipment and electrical safety.

The registered provider had no effective quality assurance system in place.

We recommended that the registered provider looks into the dining experience for people who used the service. We recommended action is taken to make care plans more person centred and to ensure people are involved in their development and review where they are able.

We found there were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered 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

The service was not always safe

Staff were recruited safely to meet the needs of the people living at the service.

People living at the service told us they felt safe. Staff were clear on what constituted as abuse and had a clear understanding of the procedures in place to safeguard vulnerable people and how to raise a safeguarding alert. However they were restricting people's liberty even when DoLS authorisation requests had been rejected.

People spoke positively of staff attitude and on the day of the visit no major concerns were raised regarding staffing levels. We saw staffing numbers at the service was not always provided at the level of their own dependency tool.

Risks were not always appropriately assessed and action was not taken to ensure risks to people were reduced.

Cleanliness and infection control procedures required attention especially in bathroom and toilet areas.

Accidents and incidents were not monitored sufficiently by the acting manager to ensure any trends were identified and lessons learnt.

The management of medicines required improvement.

Is the service effective?

Requires improvement

This service was not always effective.

People were not well supported to have their nutritional needs met and mealtimes were not always well supported. Communication between care and kitchen staff regarding people's nutritional needs required improvement.

Staff had not received regular supervision. Training was monitored and most staff were up to date with mandatory training requirements.

Management did not understand when a DoLS application should be made. Staff did not understand the Mental Capacity Act 2005, the requirements of the associated code of practice and when to apply for a Deprivations of Liberties (DoLS).

Is the service caring?

Good

This service was caring.

People told us they were happy with the care and support they received and their needs had been met.

Summary of findings

It was clear from our observations and from speaking with staff they had a good understanding of people's care and support needs and knew people well.

Wherever possible, people were involved in making decisions about their care and independence was promoted. We saw people's privacy and dignity was respected by staff.

Is the service responsive?

Requires improvement

This service was not always responsive.

People's care plans met their basic needs but required improvement to show how people were involved in their development and review.

The service provided a choice of activities and people's choices were respected.

There was a complaints procedure and people said they knew how to complain. Complaints were not fully recorded and it was difficult to determine if these had been appropriately investigated.

Is the service well-led?

Inadequate

The service was not well-led.

There were not effective systems in place to monitor and improve the quality of the service provided.

People's views were not regularly sought regarding the running of the service.

The acting manager failed to look into concerns raised around the behaviour of staff or provide appropriate supervision. They failed to take action to monitor risk and take action to reduce the potential of these occurring.

Wellburn House

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.

The inspection visit took place over one day on 15 July 2015. This visit was unannounced which meant the staff and provider did not know we were visiting. The inspection team consisted of three adult social care inspectors, a specialist advisor with a nursing background and an expert by experience who was a family carer for an older person.

The provider was not asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed all of the information we held about the service including statutory notifications we had received from the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale.

During our inspection we spoke with thirteen people who lived in the home, seven visitors, six care staff, two ancillary staff, the chef, the deputy manager, acting manager and regional manager. We observed care and support in communal areas and spoke with people in private. We also looked at care records of six people to see if their records matched with the care needs they said they had or staff told us about. We also looked at records that related to how the service was managed.

As part of the inspection process we also reviewed information received from the local authority who commissioned the service.

Requires improvement

Is the service safe?

Our findings

Staff we spoke with had a good understanding of how to keep people safe. They told us; "People are safe and secure, we keep them secure for their own safety," and "The windows have restrictors on to keep them safe."

Staff knew different types of abuse and how to take further action if needed. The staff we talked to were aware of the needs of people and were very aware of safeguarding and whistleblowing [telling someone]. One staff member stated "We get training in that and know how important it is and yes I would speak up". However the manager had not taken action to review night staff practice when allegations were made that they were asleep on duty.

One section of the building was not currently in use by people using the service with none of the bedrooms occupied or bathrooms used. When we first arrived an area of this disused corridor was very cluttered with an empty clothes airer, a large box of what may have been Christmas decorations or activities equipment and a number of flattened cardboard boxes. Although this section was closed off to residents it was a potential hazard to members of staff who did use the space also a potential fire hazard. Later in the day this area had been tidied.

The toilets on this corridor were not in use and therefore the fact that there was no soap, hand towels or bags in bins was not of concern however it was noted that the toilets were not clean.

The staff room was in this section of the home and had the appearance of being partially refurbished. There was no skirting board in the room and there were also no chairs for staff to make adequate use the facility as a break area. One staff member said that staff took their breaks outside during the good weather but it was not clear what the alternative was for other conditions. We were told by people who used the service and staff that you had to; "Go out the back to smoke even in bad weather". The staff lockers were very difficult to access being blocked by air conditioning units that were reportedly not working and being stored there.

In the unit for people living with a dementia, a number of the bathrooms, shower rooms and toilets in this area of the building were poorly maintained and cleaned. The majority of fixtures appeared to be dated and in need of replacing. Toilets were not cleaned adequately and a number of the seats were badly fitting, old and stained; there were a number of bins without bags and some of the pedal bins were not in working order. One pedal bin was found to contain discarded incontinence pads. One of the shower rooms contained a mop and bucket and the mouldy smell in the room could perhaps be attributed to this cleaning equipment having been left there for some time. In the bathroom, the bath had been recently used but not rinsed out afterwards, the room contained a commode and a bath chair both of which needed cleaning. The bath chair fixing used to anchor the chair to the bath was cracked and dirty. The shower room opposite the sluice had no soap dispenser or hand towel dispenser. There were a number of items discarded in the corner of the room including an old wooden side table and some plant pots. The pedal bin had been placed on top of the clinical waste bin making it inaccessible. We also noticed that the floor of the lift between the ground and first floor was dirty.

We spoke with a member of the domestic team who told us they completed cleaning checklists and they told us that they washed mattresses down whenever the beds had been stripped by care staff.

We found from the care records that one person had contracted head lice and scabies but we found no evidence that this had prompted staff to action to prevent the spread of these contagious disorders or to determine how the people had come into contact with carriers of these infestations.

This was a breach of regulation 15(1) and 15(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the management of medicines on both units. We found the information the pharmacy provided was not always correct. Photographs of tablets did not match the photograph of the tablet dispensed. Medicines were provided in a multi dose system, meaning that all the morning medicines were together etc. If a medication was discontinued the pharmacy collected the tray, removed the discontinued medicine and returned the tray, this could take two or three days. During these days the staff removed the discontinued medicine themselves, which meant they had to identify the medicine from the photograph and make sure they removed the correct one, since the photographs did not always match what was dispensed

there was a danger the incorrect medicine could be removed. We asked to see the risk assessments for removing discontinued medicines but we were told there wasn't one.

We looked at the quantities of boxed medicines and found some quantities did not match what had come into the service, what had been administered and what was still left. For example they had received 140 codeine phosphate for one person, they already had 28 in stock so had carried these over bringing a total to start the medication cycle to 168, they had administered 89 and there was 27 left when there should have been 79. No one could account for these missing tablets.

Cream records were not completed so where a cream was to be applied twice a day we could not see evidence of this.

Some people were taking a medication called Alendronic acid, this medication needs to be administered half an hour before any other medications, food and all drinks except tap water, they also need to remain sitting upright for the full half hour. Due to the medicine being in a pot with all other medicines they administered it at the same time. This could possibly make this medication ineffective.

We saw evidence of medicine fridge temperatures been taken daily but room temperatures to check medicines were stored correctly were not always recorded.

We saw one person had a recording on their Medication Administration Record (MAR) to say they had received some homely remedies. We asked about the control of homely remedies and we were told they don't use them. We found a box of 100 of Paracetamol in the trolley with homely remedies handwritten on the box. Homely remedies need to be recorded, stored and administered in line with NICE guidelines 1:16 and with permission from the persons GP.

Some medicines have a four week shelf life once opened such as eye drops. We saw eye drops that had a prescribed date on for 19 May 2015, but no date of opening; therefore we could not tell if these were past the four week shelf life.

Medication liable to misuse called Controlled drugs, were stored, administered and recorded correctly. Medication administration competencies were taking place.

We looked at the services medication policy and found this did not relate to the system they were currently using.

This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people were at risk, there were basic assessments in place, which described the actions staff were to take to reduce the possibility of harm. These included generic measures to be taken to reduce the risk of falls whilst encouraging people to walk independently, measures to reduce the risk of pressure ulcers developing or to ensure people were eating and drinking. However, we found staff were not taking action to use the tools fully and they were not effectively assessing anything other than very common risks.

In December 2014 it was recorded for one person that should they bump their head they must be immediately taken to hospital as they were susceptible to bleeds. This was not translated into a care plan until May 2015. On six occasions overnight the person had unwitnessed falls and on two occasions was reported to have bumped their head but this led to them being taken to hospital on only one occasion. Also this person was susceptible to prolonged nose bleeds that required medical intervention according to the notes from GP visits. This was not recorded in any care plans and the daily records showed it was a prominent feature of their needs. Despite the home being a residential service and this person's needs becoming more complex staff had taken no action to request a review to see if they could continue to meet this person's needs.

We, however, found that staff failed to assess more complex risks appropriately for instance one person had been to hospital following an injury which the A&E doctor stated was caused by a dog bite. Staff took no action to establish how this injury occurred or reduce the potential of it reoccurring.

We also saw that for two people body maps were not always updated monthly where people were at risk of developing pressure ulcers.

Accidents and incidents were not adequately monitored by the service to ensure any trends were identified. We saw patterns of incidents at night time that had not been addressed. We saw that the managers merely looked at the number that had occurred but did not establish if any measure that had been put in place were working or why incidents might have occurred.

Requires improvement

Is the service safe?

We also found that where concerns had been raised around the practices of the night staff these had not been investigated. We saw that no additional supervision was provided and from our review of records we found that the practices were different between the night staff teams and the concerns were potentially valid.

This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Maintenance staff undertook checks but where issues arose took no remedial action. For instance the hot water temperatures were recorded as less than 43°c across the home (ranging between 37°c and 42°c) and we saw that week on week for over 3 months these temperatures remained the same. No system was in place to either support the maintenance staff recognise that the appropriate temperature for hot water was 43°c, inform care staff that the water was tepid or to take action to increase the hot water temperatures.

This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not see personal emergency evacuation plan (PEEPs) available for each person in their care files, taking into account their mobility and moving and assisting needs. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency.

We observed people being moved by hoist, the task was explained, and permission sought and carried out sensitively.

On the day of the inspection there were ten care staff on duty, the deputy manager, acting manager, three domestics, two kitchen staff, an administrator, a laundry person and a maintenance person. We were told the home did not generally used agency staff but had done so in the last couple of weeks due to long term sickness and staff absenteeism.

We looked at the staff rotas for a three week period. We saw that there were usually ten care staff including a senior carer during the day and five care staff on a night. The service's own staffing risk assessment tool which had been completed for 54 people (and there were 55 on the day of our inspection) stated that there should always be six care staff on duty at night time. We fed this back to the management team at the end of the inspection to address this issue.

We saw safety checks and certificates that were all within the last twelve months for items that had been serviced and checked such as fire equipment and electrical safety.

Only one person expressed a concern that now and again there were not enough staff and staff were rushing about. However this person added "Staff are always pleasant and explain if they have to hurry". We were also told call bells are answered quickly and this was the case whilst we were in the home.

We looked at the recruitment files of the five members of staff. There was robust documentation in place to show that people had completed an application form and had attended for an interview. We could see that two referees had been contacted and provided references for each staff member. Each of the five staff members had a Disclosure and Barring Services (DBS) check prior to working at the service. This is a check which enables employers to check the criminal records of potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children.

Requires improvement

Is the service effective?

Our findings

Of the 55 people at the home the staff had submitted DoLS authorisations for 33 people. We found that prior to these being submitted staff had not completed any form of mental capacity assessment and for one person the DoLS authorisation stated that they had no form of mental disturbance. This meant that staff could not be confident that the people lacked capacity to make decisions prior to submitting the forms and were potentially attempting to illegally detain people at the home. Only people who lack capacity can be subject to a DoLS authorisation and people with capacity can either agree or not to the use of keypads and not leaving the home on their own. Staff should provide assistance such as keypad numbers for people with capacity who want to come and go as they please.

This is a breach of regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

We found that the deputy manager believed that the acceptable practice was to submit DoLS forms for everybody in a care home and did not understand the basic principles of the MCA. Neither they nor staff presumed people to have capacity and be able to take risks if they so desired.

We found that there were no formal capacity assessments for staff to complete and this had led to no decision specific capacity assessment being completed. Staff had received basic MCA and DoLS awareness training but not detailed training around how to put this legislation into practice. The staff who were responsible for completing DoLS application had not received any training around how to complete capacity assessment and were unaware that this was a pre-requisite of the process and had to be done before the authorisation was sent. Also there was no system in place to check the competency of the staff completing the DoLS authorisations.

We found that when DoLS authorisations had not been approved by the supervisory body staff had not recognised that this must lead to a change in their practice. Thus they continued to deprive people of their liberty and failed to review the care plans and look at how to support people to go out and about as they wished or even to give them the key pad numbers for the doors.

We found no evidence to show that staff checked whether family had any legal authority such as lasting power of attorney care and welfare prior to asking them to make decisions on behalf of the person or sign care plans.

Staff were not aware that people had the right to challenge DoLS authorisations at the Court of Protection and therefore did not enable people to get representation.Consent records were not always appropriately signed by the person or their representative in their care records.

This was a breach of regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff about the duration and content of the induction programme, together with their views, they told us; “I worked on the floor after my forms were in, could not do all of the job until I had moving and handling training, had a walk around, I was shown fire doors and went into the office,” and “I was shown around, saw the fire exits, had two days shadowing, did moving and handling training and then did it all.”

When asked about the mandatory and specialised training they had undertaken, together with how their competency (**combination of training, skills, experience and knowledge that a person has and their ability to apply them to perform a task safely)** was measured and what they had learnt from attending this training staff told us; “I can’t remember, the courses are on the board, not had end of life training and not sure if I’ve had nutrition and hydration training.” And “I have had equality and diversity, fire awareness, moving and handling, nutrition and hydration, no end of life training; learnt about moving and handling.”

We saw there was a training matrix in place and staff were asked to check an updated list outside the administrators office to see when they were booked on mandatory training refreshers. Training booked for the month of July 2015 included equality and diversity, infection prevention, tissue viability, fire simulation and falls management and bedrails.

From a review of the appraisal and supervision documentation we found that staff received group supervision but this was inconsistently applied. So some staff would receive a number of sessions whilst more than half of the team had received none. Also it was not clear

why or how the topics for group sessions, as one group had sessions on recording information and nutrition whilst the other groups did not. Supervision sessions had not been completed for seven staff. We found that none of the night staff received supervision but some were spoken to about why they had been asked not to come into work. None of the documents suggested the acting manager had explored with these staff any concerns that may have been raised.

When asked about how frequently they had supervision sessions/meetings with the acting manager, together with what was discussed they told us; "None since I've been here, and "No, I haven't had any." This meant that staff had not been offered support in their work role; In addition there had not been the opportunity to identify the need for any additional training and support.

We saw that none of the staff had received appraisals in the last five months and of the 25 staff records were reviewed only one member of staff had an appraisal record in place for the last year.

This was a breach of regulation 18[2]) of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Do Not Attempt Resuscitation [DNAR] forms were included for people and we saw that the correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form. However staff were unaware that these should only be in place for people who are terminal and for other people should they not wish to be resuscitated they should complete advanced directives.

The Malnutrition Universal Screening Tool [MUST] risk assessment was used to identify specific risks associated with people and was formally reviewed each month. Where people were identified as being at risk of malnutrition, we saw that referrals had been made to the dietician for specialist advice.

We saw that people were weighed in accordance with the frequency determined by the nutritional risk assessment tool (MUST), to determine if they were at risk of malnutrition. This information was used to update risk assessments and/or refer to the GP/dietician for additional support or advice if weight loss was identified. We saw food and fluid charts – where people were identified as being at risk from malnutrition their food and fluid intakes were generally well completed.

We saw for one person who had diabetes that it was recorded in their specific care plan that they followed a sugar free diet. However, we were unable to see notification to the kitchen regarding food likes, dislikes and dietary needs. One care staff told us that they verbally gave the dietary information to the kitchen and said "We complete the preferences section, if they don't like something we tell the kitchen staff, or if they have a reaction to something, we don't have forms". Whereas, the chef told us the care staff provided them with a 'diet notification form'. When we reviewed the 'diet notification file' which the chef gave us we saw that this had last been updated in 2012; the chef told us "we did have a diet sheet but it got splattered".

This meant there wasn't good communication between care and catering staff to support people's nutritional well-being.

This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the ground floor lounge, drinks and snacks were available and we observed staff assisting people opening packets of biscuits that they had chosen themselves from the selection. The service had a pleasant garden to the rear and a staff member said that people did access the garden in nice weather however we did not observe anyone outdoors on the day we visited which was a particularly nice, sunny day.

We were told; "The food here is great and you get plenty of choice". Another stated "the home is good, staff are helpful and nice, the food is good with plenty of choice".

We observed lunchtime meals in two different dining areas. People seemed happy with the food although there were many complaints that it was just warm not hot. One carer warmed the food in a microwave before serving it.

One comment made to us was about a wobbly table, people eating lunch said "I wish they could do something about the wobbly table." We spoke to a carer who turned round and said "They are all like that."

Requires improvement

Is the service effective?

We observed lunch in the downstairs dining room. The menu was written on a chalk board on the wall and there was a list of alternative meals. There were pictures of meals on the doors to the dining room but not of the meal of the day. The tables were nicely set and the room was bright and well decorated. Lunch was gammon with carrots and peas followed by rice pudding. People were asked if they wanted this meal or an alternative which was explained.

The meal was well presented and most people ate all of their meal. A couple of people said the meal could have been warmer and when they had a small portion of the gammon, although very tasty it was only lukewarm. People were asked for permission before staff put aprons on them.

A juice drink was provided but no hot drink. We were told people could ask if they wanted a hot drink. When we asked we were told a hot drink was provided for people on the dementia unit and that was the way it had always been with people downstairs asking for a hot drink if they wanted one.

We observed that meals taken to rooms were not carried on a tray or covered, this could also mean they were not kept warm and liable to possible contamination.

There were a couple of people who needed assistance with eating but the meals were put on the table and allowed to go cold as no specified member of staff was available. This was attended to when we pointed out the meals were going cold and assistance was required.

We recommend that the registered provider looks into the dining experience for people who used the service.

Good

Is the service caring?

Our findings

People told us they were very happy at Wellburn House. We were told "I am treated with respect and yes my dignity is looked after. Staff are pleasant and helpful and I am well looked after". Another person said "Everything about this home is good, you would struggle to find fault".

There was good interaction between staff and people who used the service and we observed staff talking to people about family visits. Staff told us they felt confident in relating to people and caring for them as they were aware of their needs and had received training in care. During our visit we observed people being involved in decisions about their day to day lives. For example, decisions about what they wanted to wear eat and drink. One staff member told us; "I offer choice, such as hold two outfits up or show two plates of food." Those people who were able had free movement around the service and could choose where to sit and spend their recreational time. This helped to ensure that people received care and support in the way that they wanted to.

We asked staff about how they maintained privacy and dignity for people. They told us; "I close doors, speak to people as I would like to be spoken to," and "I always provide choice, such as the menu the day before." We observed staff knocking on doors before entering a room and asking permission to carry out care tasks. Everyone we spoke with said they were treated with dignity and respect and that staff would listen to what they had to say and talk to them.

Staff that we spoke with showed concern for people's wellbeing. It was evident from discussion that all staff knew people well, including their personal history, preferences, likes and dislikes. Staff were aware of how best to support people. Staff were able to describe each individual person's care in detail and what was important to them. One staff member told us; "I talk to people about their past, where they lived, family etc., I incorporate this into their care plan."

Another staff member said; "They value their one to one's, I would love to give them more, I do as much interaction as possible, such as I talk to them a lot whilst supporting them."

We witnessed one of the senior carer's talking to a visitor in a very knowledgeable and sympathetic manner about the effect dementia had on their relative. They empathised with the difficulty of putting their relative in a care home and their conversation was caring and reassuring.

We asked staff about how they promote independence. They told us; "Don't rush to feed someone if they are taking their time, I ask if they want help, if not they can take as much time as they want." We saw staff encouraging people to be independent by giving them choice e.g. getting involved in activities, asking if they would like a drink, asking what they would like to eat, and where they would like to sit. A staff member told us; "We have one person who loves to help, he peels the potatoes, with support and prevention of risks, he also folds the napkins and really enjoys helping, as he feels active."

Staff told us about how they provided end of life care. "We work with the District Nurses, we provide a lot for the family, we are there if they want to talk or don't want to talk, I always sit with someone who is dying they are never left alone. Families are welcome any time and never rushed." We saw an advanced care planning assessment/ end of life care plan for people. This meant that information was available to inform staff of the person's wishes at this important time to ensure that their final wishes could be met.

Visitors stated they were happy with care given and the range of activities available for people.

Visitors also said they were confident about expressing a view to staff on caring matters. They also stated they could visit at any time with one person saying they visited early morning because it fitted in with their day.

Requires improvement

Is the service responsive?

Our findings

There was a full activities programme on display and staff were busy decorating for the summer fare which was taking place that weekend.

There was one full time activities organiser and two part-time and when we talked to them they were full of enthusiasm about their work. During the morning there was a short quiz, skittles and a card game which people seemed to enjoy – there were 14 residents attending. The afternoon session was also well attended with music and games. Monthly themed days were organised such as Mexican and French, and outings were arranged although the service did not have a minibus. One organiser told us; "I have taken out some insurance on my car so I can transport people if we do not need a bus". We asked if they had received any financial assistance with this but they said not. Activity staff also told us about a recent event for Dignity Day where they looked at photographs and discussed the changing face of the town of Stockton.

Both people and visitors confirmed outings take place. People had recently attended an armed forces parade in Stockton and one person in particular talked about how they had enjoyed it and had also seen old friends.

There was an individual record of involvement in activities but this only stated "Enjoyed", and did not qualify the degree of engagement the person had had in the activity.

One person told us; "We do bingo, quizzes, the activity co-ordinators are not full time and often accompany people on hospital appointments rather than doing activities."

One visitor stated "It would be helpful if there was a simple care note in the room so I could read what care had been given such as a bath, eating and drinks taken. Staff do not tell me even though they are friendly and say hello".

We were sitting in the lounge observing people when a confused person started to gently hit us with a zimmer frame and use nasty language. Staff immediately responded to this and distracted the person who began to calm down. We were told "This sometimes happens and we know how to distract X and they will calm down".

We saw people's records included details of appointments with and visits by health and social care professionals such as the General Practitioner (GP), district nurse, Tissue Viability Nurse, chiropodist. This demonstrated that the expertise of appropriate professional colleagues was available to ensure that the individual needs of the people were being met, to maintain their health. One person told us; "They had to call the doctor for me recently and they did so quickly". This was confirmed by a visitor who said "I am contacted quickly if there are any health concerns".

We saw pre-admission assessments in care files and care plans were developed detailing the care needs and support, actions and responsibilities to ensure personalised care was provided to all people. The care plans guided the work of care team members and were used as a basis for quality, continuity of care and risk management.

The care plans we looked at did include a dependency needs score, which meant that there was a summary of the care requirements of people living at the home, to ensure that staff had the capacity and skills to be able to provide appropriate care.

The care plans were found to be detailed and gave an overview of people's individual needs and how they required assistance. However, the care planning system was confusing to follow, with the care plan index inconsistently numbered together with a mixture of new and old risk assessments contained in the care file. The service's management team explained to us that they were in the process of transferring from an old to a new format. From the care plans we looked at it was clear that people's individual needs had been assessed before they moved to the service. The assessments were used to design plans of care for people's individual daily needs such as mobility, personal hygiene, nutrition and health needs. The care plans were detailed and provided guidance for staff about how to support each person with their specific needs.

People's care records did not appear to be personalised to reflect their individual preferences, support and what they could manage for themselves.

Care plans were reviewed monthly and on a more regular basis, in line with any changing needs; they were duly signed and dated by a senior member of staff. Staff told us that senior care staff were responsible for updating designated people's care plans and we saw that care plans had been reviewed. Care plan reviews did not show if people and their relatives were involved in the care planning and review process. The reviews had not always

Requires improvement

Is the service responsive?

been signed by people to show that they agreed with the plan which had been put in place. This meant that we did not know if people were involved in making decisions about the care and support which they needed. Daily records were completed but care should be taken to ensure abbreviations are explained.

We recommend action is taken to make care plans more person centred and to ensure people are involved in their development and review where they are able.

We looked at how the service dealt with complaints. We looked in the complaints folder and found that minimal complaints were recorded. We found more evidence in the care records than what was recorded in the complaints file about what the concern was and how it had been responded to.

We could not see a complaints policy on display and the one in the office incorrectly referenced CQC. People we spoke with who used the service and relatives said they had not made any complaints.

Inadequate

Is the service well-led?

Our findings

The acting manager was visible walking around the service and was speaking to people and there was a calm atmosphere. Staff stated they were happy working in the home and visitors felt their views were listened to by staff.

We found that there were no systems in place to ensure that events and incidents were identified and action taken to rectify them. For example the accident/incident file showed that at 12:05am and 12:15am on 9 June 2015 two people had been found on the floor of their rooms. The falls had not been witnessed and it was noted that their bed sensors had either not gone off or were not working. There was no evidence of a follow up to this and it was not clear whether or not the issue has been investigated or resolved. The service were collating the amount of falls each month but no actions were taken to look for trends or patterns. From a review of falls we found that albeit staff referred people to the falls team they did not ensure the advice was subsequently reflected in care records. Neither did staff look at what actions could be taken to reduce the incidents of falls during the night or when pressure sensors failed what remedial action could be swiftly taken.

We saw that a lot of falls happened at night, yet this had not been picked up and no spot checks by management had taken place at night. Although issues had been raised in respect of night staff behaviour no specific supervision sessions had been completed with them. Sessions had been completed with staff that had recently been suspended but the notes recorded that these merely explained that the suspension process protected them. Senior staff confirmed they had taken no action to monitor staff practices overnight or complete random checks. It was clear from the information we reviewed that there were two night staff teams and there were marked differences in practices between these staff.

This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that care plan audits were varied in quality. We also saw that other audits such as medicines, infection control, health and safety and accident audits were either incomplete or not in place. The ones completed by the regional manager recently were very good detailing actions and by when they required completion, however some of the action dates had already passed and they did not record that they had been completed. The regional manager and acting manager confirmed that they realised that the governance arrangements were poor and needed improving. They stated that this was area they were looking to develop.

We asked staff about whether they felt supported by the management team, they told us; “The manager and deputy are both learning their new roles, they have a lot to do but they need to be stronger with issues such as smoking breaks and family relationships [staff working with their own relatives].” And “I feel the management are open and honest.” One staff member said there are lots of family members working together on the same shifts that can make things quite awkward for quieter people as they don’t involve them.

We asked staff about how frequently they had staff meetings with the acting manager, together with what was discussed they told us; “Not been to one,” “I haven’t been to one, there was one two weeks after I started” and “We have not had one for a while, it’s not usually a good turn out.” We saw from records there had been a meeting for day staff on 26th March and one meeting for night staff on 10th June 2015.

This meant that mechanisms were not in place to give staff the opportunity to contribute to the running of the service, together with communicating key information to staff to ensure standards of care were maintained and improved.

Visitors we spoke with could not recall having been given a survey form to complete and the most recent survey result we obtained from March 2015 showed only staff had completed a questionnaire. There was no action plan from this staff feedback so we could not see how the service had addressed the issues staff may have raised. There had been a “Relatives and residents” meeting in June 2015 where outings, snacks and drinks and the recent care homes open day had been discussed.

This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People may have been at risk of receiving incorrect nutritional intake due to lack of up to date records in the kitchen.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment All premises and equipment used by the service provider must be clean. The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Consent must be sought before any care or treatment is provided.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services We saw that care plan audits were varied in quality, other audits were not in place or were incomplete. Surveys on the views of people were also lacking.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were deprived of their liberty without lawful authority.