Malhotra Care Homes Limited

Heatherfield Care Home

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**

Summary of findings

Overall summary

We last inspected Heatherfield Care Home in December 2016 where we identified two breaches of the regulations relating to safe care and treatment and good governance. We rated the service 'requires improvement.'

Following our inspection, the provider sent us an action plan which stated what action they were going to take to improve.

Heatherfield Care Home provides accommodation and care for up to 74 people. The home is divided into three units for those who have general nursing, dementia care and younger physically disabled needs. Accommodation is spread over two floors. There were 68 people living at the home at the time of the inspection.

A manager was in post. She had commenced employment in May 2017 and applied to register with the Care Quality Commission as a registered manager. 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.

Prior to the inspection, we received information of concern regarding staffing levels, the maintenance of records and certain aspects of people's care. We brought forward our planned inspection in order to check the concerns raised.

There were continued shortfalls and omissions with regards to the management of medicines. We identified concerns with the care and treatment of people who required enteral feeding. Enteral feeding refers to the delivery of a nutritionally complete feed via a tube, directly into the stomach or bowel.

A high number of agency staff were used. At the time of the inspection, we found there were insufficient suitably qualified, competent, skilled and experienced staff employed.

Staff were knowledgeable about safeguarding and told us they would report any concerns. There were three ongoing safeguarding investigations. Two of these were being investigated by the police. We will monitor the outcome of these safeguarding investigations and action taken by the provider.

The local authority had placed the service into organisational safeguarding. This meant that the local authority was monitoring the whole home.

There was a lack of evidence to demonstrate that safeguarding incidents were monitored and lessons to be learned considered to help identify any changes in practice to ensure continuous improvement.

The training matrix had gaps against certain training courses. Some people, relatives and staff raised concerns about the communication and skills of agency workers. Records of the clinical skills and competencies were not available for most of the agency nurses. There was no evidence of clinical supervision.

We checked the design and décor of the service. There were extensive accessible gardens which had won a number of awards. The service had its own hydrotherapy pool. There was an additional charge if people wished to use this facility. The service also had a cinema room, hairdressing salon and kitchen areas where people could make hot drinks and prepare snacks. However, we found that not all aspects of the environment met best practice guidance relating to supportive environments for people living with dementia. We recommended that the design and decoration of the premises is based on current best practice in relation to the specialist needs of people living at the service.

Some people's care records had omissions. This meant it was not clear whether care and treatment had been provided.

A complaints procedure was in place. We found however, that not all complaints were recorded or dealt with in line with the provider's complaints procedure.

An activities programme was in place. Some people and relatives told us that more activities would be appreciated. We recommended that access to and the variety of activities available is kept under review in light of the feedback we received.

We observed positive interactions between staff and people. Staff spoke with people respectfully and provided discreet support.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We found shortfalls in many areas of the service including the management of medicines, training, the care and treatment for those who required enteral feeding and dealing with complaints. In addition, records relating to people, staff and the management of the service were not always accurate, complete or securely maintained.

Since 2013, we found the provider was breaching one or more regulations at five of our six inspections. This meant that systems were not fully in place to ensure compliance with the regulations and good outcomes for people.

Following our inspection, the head of compliance sent us an action plan and further information detailing the actions they had taken/planned to take to address the shortfalls we identified.

We found four breaches of the Health and Social Care Act 2008. These related to safe care and treatment, staffing, receiving and acting on complaints and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

There were insufficient suitably qualified, competent, skilled and experienced staff deployed to ensure care was delivered as planned.

There were continued shortfalls and omissions in the management of medicines.

Pre-employment checks were carried out prior to staff starting work at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

There was a lack of evidence to confirm the competency and skills of nursing staff. The training matrix had gaps against certain training courses.

Not all aspects of the environment met best practice guidance relating to supportive environments for people living with dementia

We received mixed feedback about meals at the home. The dining room experience for those living with dementia had improved.

Is the service caring?

Good

The service was caring.

Most people and relatives told us that the permanent staff were caring.

We observed positive interactions between staff and people.

Staff spoke with people respectfully and provided discreet support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people's care records had omissions. This meant it was not clear whether care and treatment had been provided.

A complaints procedure was in place. We found however, that not all complaints were recorded or dealt with in line with the provider's complaints procedure.

An activities programme was in place. Some people and relatives told us that more activities would be appreciated.

Is the service well-led?

Inadequate

The service was not well-led.

We identified continued shortfalls in medicines, the maintenance of records and training.

Since 2013, we found the provider was breaching one or more regulations at five of our six inspections. This meant that systems were not fully in place to ensure compliance with the regulations and good outcomes for people.

There was a manager in post. She had applied to register with CQC as a registered manager.

Heatherfield Care Home

Detailed findings

Background to this inspection

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

Heatherfield Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home can accommodate up to 74 people. The home is divided into three units for those who have general nursing, dementia care and younger physically disabled care needs.

The inspection took place on 3, 8, 10 and 17 November 2017. The visit on the 3 November 2017 was unannounced. The other visits to the service were announced.

The inspection was carried out by two adult social care inspectors, an inspection manager, a specialist advisor in nutrition and two experts 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.

Due to the late scheduling of the inspection, we did not request a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection, we reviewed information we held about the service. This included 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 also reviewed two 'share your experience' forms which had been sent in to us from people telling us about the care being provided.

We contacted North Tyneside and Northumberland commissioning and safeguarding teams. We also contacted Northumberland and North Tyneside Clinical Commissioning Groups who contracted people's nursing care. We also contacted North Tyneside Healthwatch.

We spoke with the nominated individual, director of care, head of compliance, manager, deputy manager, one [day] nurse, a nursing assistant practitioner, four care workers, a member of domestic staff, a laundry assistant, the provider's estates manager and the chef. We also spoke with night staff by phone over five consecutive nights. We spoke with two agency night nurses and six care workers to find out how care was delivered at night.

During our inspection, we spoke with 10 people who lived in the home. We also spoke with eight relatives.

We contacted a community matron, GP, two social workers, podiatrist, dentist, optician, a palliative care nurse, a tissue viability nurse, a staffing agency manager, a Watch Manager from Tyne and Wear Fire Brigade and an area operations manager from a medical equipment company. We also contacted a member of staff from a local pub where people visited, a Turkish barbers, and a library.

We observed the care and support staff provided to people in the communal areas of the home and during the lunch and teatime meals. We looked at the care plans and records for nine people. We also viewed other documentation, which was relevant to the management of the service including quality monitoring systems and training records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we identified a breach in the regulation relating to safe care and treatment. Processes were not fully in place to ensure the safe management of medicines.

We have rated this key question as requires improvement at our last three inspections. This meant the provider had not ensured good outcomes for people in this area.

At this inspection, we found continuing shortfalls with in the management of medicines.

We received mixed feedback about medicines from people and relatives. Comments included, "On time and as prescribed," "Medication [time] changes all of the time I don't like it," "Sometimes they run late" and "There have been issues with his medication."

The service had recently changed from a monitored dosage system to a boxed system where all medicines were dispensed in their original packaging. Some staff were not complimentary with the change in system. They said that medicines took longer to administer and they sometimes did not finish the morning medicines round until 11.30 – 11.45am. They explained that time specific medicines were always administered on time.

We identified specific concerns relating to the management of medicines which were administered enterally [via a tube directly into a person's stomach or bowel]. One person told us that a member of staff had plunged their medicines into their specialist feeding tube. Medicines and feed should be allowed to run through the tube into the stomach/bowel with gravity. Plunging may induce the person to vomit.

The manager told us that this had been an agency nurse who had been unaware that the medicine needed to be mixed with water prior to administration. We checked this person's care plan and medicines administration record and noted that this information was not documented which meant there was a risk that this could happen again.

Medicines given enterally must also be given separately with a water flush between each medication. This ensures that the medicines do not mix with each until they are in acid or bile. There were no instructions in the care plan to do this.

One person required a pump to deliver the specialist feed. The hourly rate was prescribed at the low rate of 65mls an hour to reduce the risk of any complications. We checked the pump and noted that it was running at 104mls per hour. We stopped the pump because this rate was unsafe and immediately got the director of care who confirmed that the pump had been set incorrectly.

Some people were prescribed a medicated patch for the treatment of dementia. We noted that two people's records did not demonstrate that the application site had been rotated in line with the manufacturer's guidance to prevent side effects.

We checked the administration of topical medicines. Some people were prescribed moisturising and barrier creams for 'red skin.' Care staff recorded the administration of these creams on a topical medicines administration record. We noted that many entries stated 'not required' or 'refused.' It was not clear how topical medicines records were monitored to ensure that moisturising and barrier creams were being administered as prescribed. The manager told us that this would be addressed.

We read one person's care file and noted that they had been assessed as being at risk of choking. One document stated that they took their medicines 'one by one from a spoon' because of this risk. Another record stated that they took them all together from a pot. The person told us that staff gave them their medicines from a pot. This ambiguity meant it was not clear how the medicines should be administered to ensure the individual's safety.

We looked at how staff sought to understand, prevent and manage behaviour that the service found challenging. One person displayed behaviour which could be described as challenging to both people and staff. We observed this individual hit a member of staff. Information relating to trigger factors and proactive strategies to reduce the likelihood of this behaviour was limited. In addition, information about the person's cultural background and the effect this had on this individual's behaviour was not included. Following our inspection, the director of care told us that this person's care plan had been updated. She also told us that new strategies had been implemented which had reduced the number of behavioural incidents.

We checked the safety of the premises and equipment. The service had signed up to the 'React to Red' national campaign to reduce the risk of pressure ulcers. Although checks were carried out to ensure pressure relieving mattresses were correctly set; other checks on the safety and suitability of mattresses were not completed. For example, one mattress we checked had 'bottomed out.' This is where the base of the bed can be felt through the mattress. This meant that any pressure relieving qualities are removed. On the fourth day of our inspection, the manager told us that a mattress topper had been placed on top of this mattress. She said that full checks of all mattresses would now be carried out.

These shortfalls relating to medicines, equipment and the management of behaviour which challenges, constituted a continuing breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Safe care and treatment.

Following our inspection, the head of compliance wrote to us and stated that care plans for people who received their medicines and feed enterally; had been updated to ensure this procedure was carried out safely. In addition, training in this area had been carried out and further training was planned. We spoke with the safeguarding nurse from the local CCG. They stated that care plans they had viewed were more detailed and the person's enteral feed pump was set at the correct rate.

The service was clean and there were no malodours with the exception of one person's room which we discussed with the manager. Checks and tests had been carried out on the premises. We noted that checks of moving and handling and bath hoists had been carried out in line with the Lifting Operations and Lifting Equipment Regulations (LOLER). However, records confirming that this equipment was safe were not available. We contacted the area operations manager from the external equipment servicing company the provider used. They confirmed the equipment was safe to use.

Tyne and Wear Fire and Rescue Service had carried out a recent fire safety audit. They had issued measures which the provider needed to take to ensure they complied with the Regulatory Reform [Fire Safety] Order 2005. The provider had taken action to address the shortfalls identified.

Most people and relatives told us that more permanent staff would be appreciated. Comments included, "They are a bit short of staff and it's worse at weekends and holidays," "Extra staff would help" and "There is too much changing of staff and they could do with more staff, they are always busy."

70 agency staff had been used during the previous four weeks of our inspection including 19 agency nurses. Most nursing shifts at night were covered by agency nurses. We read a copy of the minutes from a 'residents' and relatives' meeting which was held in August 2017. The manager had stated, 'One of the biggest problems is that we use agency staff. This company will not let you run on lower numbers. If the numbers go down, you can get agency staff, but this causes instability because they don't know the residents.'

During the inspection, we identified shortfalls in enteral feeding. We also found omissions and shortfalls in the maintenance of records. The manager explained that due to the transient nature of agency staff, it was difficult at times to ensure they completed the necessary documentation.

The manager told us that due to the size of the service and complexity of people's needs, they had recognised that more supervisory staff were required to monitor care delivery. The provider had agreed to the introduction of a team leader post. The manager explained that it was envisaged there would be one team leader on each unit and two team leaders at night. Following our inspection, the head of compliance wrote to us and stated that four staff had been offered team leader posts and further interviews were planned.

The manager told us that new nursing staff had been recruited and were due to start at the home. Following our inspection, the director of care told us that five new nurses had been recruited. We took this feedback into consideration; but due to the concerns we identified at the time of the inspection and new staff not yet in post at the time of the inspection visits, we considered there were insufficient competent, skilled and experienced staff on duty to meet people's needs.

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

Most people and relatives said they felt the service was safe. Comments included, "It's safe here, there is always a carer close by" and "I feel my brother is safe as the staff know his needs and listen to what we say." One person however, told us they found an individual who lived at the home, "very intimidating." We passed this feedback to the manager.

A healthcare professional told us, "I haven't witnessed anything at the home that I have been concerned about."

Staff were knowledgeable about safeguarding and told us they would report any concerns. There were three ongoing safeguarding investigations. Two of these were being investigated by the police. We will monitor the outcome of these safeguarding investigations and action taken by the provider.

The Care Act 2014 statutory guidance includes self-neglect in the categories of abuse. We visited one person in their room and noticed that their bed was soaked in urine and there were used incontinence pads on the bathroom floor. A care worker immediately changed the bed and explained that the person often refused personal care. We spoke with the manager about this individual's care. They said they would make a referral to a relevant health and social care professional for advice regarding their refusal of personal care.

A safeguarding file was maintained. The file mainly consisted of CQC notifications or safeguarding alerts

which had been sent to the local authority. There was limited information to support the manager's investigation or consideration of lessons to be learned. The head of compliance explained that the manager had not been using the provider's safeguarding investigation report form which contained this information. On the third day of our inspection, the manager had completed these forms retrospectively for all safeguarding incidents. We noted however, that these reports were not always accurate. The manager had documented that she had received a statement from one member of staff. When we asked to see this statement, she explained that this had not been received.

One person was currently under the local authority's individual safeguarding adults procedure because of concerns relating to their care and treatment. A safeguarding meeting had been held on 12 September 2017. Actions to ensure the person's safety had been agreed. A second safeguarding meeting had been held on 7 November 2017. A number of actions identified at the meeting held on 12 September had not been completed. We also identified concerns with certain aspects of this person's care and documentation during our visits. This meant that actions identified to safeguard the individual had not been fully completed in a timely manner to ensure their safety.

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

Following our inspection visits, the head of compliance wrote to us and stated that this person's care planning documentation had been updated and training had been carried out and further training was planned with regards to this individual.

Recruitment checks were carried out prior to staff starting work. These included obtaining a Disclosure and Barring Service [DBS] check and two references. These were carried out before potential staff were employed to confirm whether applicants had a criminal record and were barred from working with people. We found minor shortfalls with certain recruitment procedures for several staff which we discussed with the manager. For example, we noted that one person's application form had been completed after they had commenced employment. Following our inspection, the head of compliance wrote to us and stated, "Interview questions for care staff have been reviewed to ensure they incorporate the six C's [care, compassion, competence, communication, courage, commitment] ensuring that staff recruited have the right approach to caring for the residents."

There was a system in place to ensure nursing staff were registered with the Nursing and Midwifery Council [NMC]. The NMC registers all nurses and midwives to make sure they are properly qualified and competent to work in the UK.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection, we rated this key question as requires improvement. The mealtime experience within some of the units was poor and training relating to people's complex needs was not yet in place. We issued recommendations regarding these two areas to ensure action was taken to improve.

At this inspection, we found continued shortfalls regarding training. The manager and head of compliance told us that training was ongoing.

We examined the training matrix and identified gaps against various training courses. The clinical training matrix was blank. The 'additional training' matrix was also blank. We identified shortfalls in enteral feeding. We asked for evidence of training and competency checks in this area. We were provided with training records for two staff for enteral feeding.

We looked at four staff induction records. The induction record stated that the manager should meet with the new member of staff on day one, week two, week six and week 12. None of the four induction records we viewed demonstrated that the manager had met with staff. There was also a delay in the completion of certain training. We noted that one member of staff had completed documentation training, fire safety, health and safety awareness and moving and handling nearly two months after they commenced employment. Three of the four records we examined had omissions in training which should have been completed as part of the provider's induction to the service.

A high number of agency staff were used. There had been 70 different agency staff on duty on the four weeks prior to our inspection.

Some people and relatives raised concerns about the communication and skills of agency staff. One individual told us that an agency worker had tried to give them a shower with toothpaste. They also informed us that an agency worker had assisted them onto the toilet with the toilet lid closed. When the person pointed this out to the agency worker; they lifted both the toilet lid and seat up and assisted the person to sit on the toilet rim. Other comments included, "Normal staff are good, agency staff haven't got a clue," "Some of them are not well trained," "I think they recruit the wrong staff, I can't understand some of their accents. Some don't speak good English," "I don't think they are well trained, I have to explain everything to them" and "There is a language problem with some of them, they are difficult to understand."

We checked the profiles of agency nurses and noted that the clinical skills and competencies of agency staff were not always available. This omission meant that the clinical skills and competencies of agency staff who provided nursing care were not known and thus the provider could not ensure care and treatment could be provided safely, effectively and in a timely manner.

There was no evidence of clinical supervision. Clinical supervision is a formal process of professional support and learning which enables staff to develop their knowledge and competence.

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

Following our inspection, the head of compliance sent us a training plan which detailed training which had been completed and was planned in the near future. This included enteral feeding and training around the specific needs and conditions of people. She also stated, "One of the [relatives] introduced to the home a gentleman who speaks about and trains staff in Huntingdon's awareness. The staff have arranged for this person to attend the home and speak to /train the staff in Huntingdons from an experiential perspective."

Most staff told us they felt supported. The manager told us, "Supervisions are work in progress, we've been training people to do them." A plan was in place to ensure all staff had regular supervision and an annual appraisal. Supervision and appraisals are used to review staff performance and identify any training or support requirements.

We checked whether the design and décor of the premises met the needs of people. There were extensive accessible gardens which had won a number of awards. People told us that these were appreciated and enjoyed. The service had its own hydrotherapy pool. There was an additional charge if people wished to use this facility. The service also had a cinema room, hairdressing salon and kitchen areas where people could make hot drinks and prepare snacks.

At our last inspection, we stated, 'We could see no evidence that the environment had been adapted to help to create meaningful activities for people with dementia. The registered manager advised us they were researching ways to improve this further and were researching best practice to maximise the environment so it enhanced people's experience.'

Several environmental features were in place to support people living with dementia. Bathrooms and toilets had signs which included the word and a picture to maximise the potential for people to recognise the information. Some bathrooms that contained a toilet, only had a bath sign. This meant that people looking for a toilet might be unaware that some bathrooms also had a toilet. Certain toilet seats contrasted against white bathroom walls and flooring, but they were not provided in every bathroom. Toilet doors were painted a bright colour to aid identification. A 'Welcome to your dining room' sign was bright and easy to see and served as a reminder as to the purpose of the room. A clock was in the dining room and was easily visible. One person said, "Is that the right time? 12.35pm?" There were murals of trees and birds on the walls in the dining room which added interest.

More seating areas had been created in the dementia unit which made corridors less sparse and created a more homely atmosphere. We observed people sitting companionably on sofas with friends throughout the day, watching people as they went by.
However, we found that not all aspects of the environment met best practice guidance relating to supportive environments for people living with dementia.

Flooring contained inlaid patterns which can cause difficulty for people living with dementia since they may perceive patterns as objects and bend down to pick them up; or misinterpret designs for changes in flooring levels. Carpets in the younger physically disabled unit were also heavily patterned with a wave design which could cause similar problems for people experiencing neurological difficulties.

Lighting was very subdued in some areas of the home including communal areas, bedrooms and en suite bathrooms. People over the age of 75 and particularly those living with dementia need more light to be able to see satisfactorily, "Poor lighting can increase anxiety and may lead to fall and trip accidents." [University

of Stirling Dementia Services Development Centre].

Some seating was very dark in colour. Seats were against a very dark wall in one of the lounges. Best practice suggests that seating should contrast with flooring and walls so they are easily identifiable for people with dementia related conditions.

We recommend that the design and decoration of the premises is based on current best practice in relation to the specialist needs of people living at the service.

The director of care, head of compliance and manager told us that the dementia care environment was being addressed.

We received mixed feedback about meals at the home. One person told us, "I can have almost anything I fancy, I asked the cook for some melon and he got it for me, they are very accommodating." Others, especially in the younger physically disabled unit said that the menus were often repetitive and there was a focus on chips.
The mealtime experience in the dementia care unit had improved. Tables were now attractively set and quiet music played. Two settings were now held which meant staff had more time to support people. Staff were attentive to people's needs in the dementia unit. We heard one staff member say, "Would you like me to open the yogurt for you?" The person replied, "Yes please you clever girl." The staff member added, "If you want another let me know because they are only small."

We also observed the dining room experience in the younger physically disabled unit. One person started drinking directly from the water jug since there were no glasses on the table. A member of staff took the jug off them and placed it back in the centre of the table without providing a drink to the person. Another person was using a vaping machine in the middle of the dining room. Several people in the younger physically disabled unit raised concerns about the behaviour of one person during mealtimes. One person said, "I don't think there is enough staff especially at feed times, some residents make it worse." We informed the manager of our observations.

On the first, second and third days of our inspection, there was a lack of fresh fruit available. We examined the menu and noted it would be very difficult for people to obtain five portions of fruit and vegetables as recommended in the governments Eat Well Guide. On the fourth day of our inspection, platters of fruit were available and bowls of fruit were available throughout the home.

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 authorisation 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.

The manager had submitted DoLS applications in line with legal requirements. We saw examples of mental capacity assessments and best interests decisions. These had been carried out for any specific decisions such as any restrictions on people's movements, including the use of bed rails.

We checked how people were supported to maintain good health and have access to healthcare services. We saw evidence in records that staff had worked with various agencies and accessed other services when people's needs had changed, for example, consultants, GPs, speech and language therapist, dietitians, the chiropodist and dentist. This demonstrated that the expertise of appropriate professional colleagues was available to ensure that the individual needs of people were met to maintain their health.

Good

Is the service caring?

Our findings

Most people and relatives told us that the permanent staff were caring. Comments included, "Staff are lovely," "Yeah they just care," "Yes I like the way they speak to him I have seen them go to help residents in the lounge who look uncomfortable," "I come about 8am and stay all day. The staff are very nice to me as well, they are always bringing me cups of tea," "The lasses are lovely," "It's a happy place, they are always laughing" and "It's all right here, they look after me." Some people and relatives told us that agency staff did not always know their needs. Comments from healthcare professionals included, "I have found the staff pleasant and welcoming" and "Staff show compassion and kindness to residents when I visit."

We observed positive interactions between staff and people. Staff displayed kindness and patience with people. One staff member told a person, "Take your time, we have all day." We heard another person at the dining table start to shout. Staff immediately went over and assisted the person out of the dining room. We saw them shortly after lunch looking comfortable in bed and fast asleep. A staff member told us that the individual got uncomfortable after sitting for a while. They explained that they communicated their need for comfort by vocalising so staff responded as soon as they appeared in distress.

We heard one person telling a staff member, "They [staff] think it's dinner time. It's not, it's my breakfast." The staff member touched them reassuringly on their shoulder and said, "I'll correct them." They did not try to explain or argue with the person that it was in fact lunchtime and cause more upset. The person responded well to this and continued to eat their meal.

One care worker had come in on her day off to take a person to Newcastle to go shopping and to see Fenwick's Christmas window display [department store].

Most people and relatives said that staff promoted people's dignity. Comments included, "They are very kind and very respectful, so much that they send my husband out of the room if I am getting personal care" and "It's good to see they respect her privacy." A healthcare professional said, "From my observations, staff at the home treat their residents with dignity and respect and residents are treated with kindness from staff members I have observed."

Staff were able to give examples about how they supported people with their dignity. A care worker said, "One person can sometimes believe they are in the bathroom and begin to take their clothes off in communal areas. They never manage to take all their clothes off because there is always someone there to help them." This example showed that staff were aware of the need to intervene to protect the dignity of people involved. The staff member explained that all interventions were carried out with a minimum of fuss and staff redirected the person sensitively and discreetly.

Staff spoke in hushed tones about personal care needs. We observed however, that some people's clothing and slippers were clearly marked with their names. Although we recognised the importance of naming individual clothing, we spoke with the manager about this being done discreetly. Following our inspection, the head of compliance wrote to us and stated, "A dignity board has been introduced informing staff of

dignity issues and giving information on how we should promote it. A dignity champion has been allocated."

'Resident and relatives' meetings' were held to obtain feedback. In addition care reviews were carried out. Following our inspection, the head of compliance wrote to us and stated, "The home has introduced a collaborative care planning document which facilitates resident and relative involvement in care planning."

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection, we rated this key question as requires improvement. We identified a breach in good governance which related to the maintenance of care plans. In addition, some people told us there were not enough activities to occupy their attention.

At this inspection, we found that some people's care records had omissions. Therefore, it was not always clear whether care and treatment had been carried out.
Care plans relating to enteral feeding lacked important information about equipment and care of the enteral tube site. One person who had lived at the home for a month did not have any care plans in place.

Bowel charts were kept. These are important since people who are unable to communicate their needs may experience behavioural disturbance and distress if they are constipated. We noted there were long gaps in these charts which indicated that people's bowel movements were not being monitored or acted upon. For example, it appeared that two people had not moved their bowels for over a month. There was no evidence they had been checked for signs of constipation and action taken if necessary.

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

The provider had organised a peripatetic manager to help address the shortfalls and omissions in care records. Following our inspection, the head of compliance wrote to us and stated that action had been taken to address the concerns we raised and care plans had been updated. We spoke with the safeguarding nurse. They confirmed there had been improvements in the five care plans they had examined.

Most people and relatives told us that permanent staff were responsive to their needs. Comments included, "They are a smashing lot of girls" and "They work very hard to help us." Most people and relatives raised concerns about the responsiveness of agency staff.

Some people and relatives told us that more activities would be appreciated especially on the younger physically disabled persons' unit. People on this unit said they would like to do more communal and competitive games like bingo. Other comments included, "There is not much in the way of activities," "There is nothing much going on in the way of activities. I have brought them lots of craft things in but never seen them use any of it," "They could give him sensory items to feel, or he loves to listen to certain kinds of music, I think they should do this for him," "[I would like to do] bingo, darts, fishing, shopping, arcade, snooker, Just to go out, I have not been out for more than three months. Trip to the cinema would be great," "I can go where I want inside, I never go out, I would love to go shopping or to the cinema or to an arcade. I have not been out for at least three months" and "The activities are not very interesting."

Other people told us there were sufficient activities to keep them occupied. One person told us, "I can go anywhere in my powered chair inside and out. I often go to the local shops." Another person told us that staff supported him to go to the local barbershop. He also helped with the gardening. One person was

having her nails manicured. She told us, "It's lovely; I like my nails to be nice."

There were four activities coordinators employed. Several people, relatives and staff told us they considered that activities provision needed to be better organised. Comments included, "It's [activities] not organised very well," "The activities girls walk round in threes all the time" and "The activities girls go round together." We passed this feedback to the manager.

Staff told us that they also supported people to go to the local pub. We spoke with a member of staff from this pub. She told us that sometimes people visited for lunch. She said, "They all seem nice and the staff seem good."

Staff explained the importance of animals and pets to people's emotional wellbeing. They said that pets were welcome. A volunteer visited with her dog during our inspection. Pamper sessions, cooking; bread making and craft sessions were carried out on the days of our inspection.

The service had a hydrotherapy pool. One person told us however, "I am disappointed that I can't use the pool. I can stand up in the pool, I can't stand up normally." The manager informed us there was, "very limited use of the pool because of the funding. People need to pay additionally for a physio to be there."

We recommend that access to and the variety of activities available is kept under review in light of the feedback we received.

Following our inspection, the head of compliance wrote to us and stated, "Experienced activities coordinators from a sister home have been supporting the activities coordinators and are currently working on rummage boxes and memory boxes."

There was a complaints procedure in place. We noted however, not all complaints were recorded. One relative told us they had raised multiple complaints and had not received any written response to the concerns they raised which were ongoing. The manager stated that weekly meetings were being held. The relative told us however, that these were not being held and only one brief meeting had taken place.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

Inadequate

Is the service well-led?

Our findings

At our previous inspection, we rated this key question as requires improvement. We identified a breach in the regulation relating to good governance. Following our inspection, the provider submitted an action plan, which stated what action they were going to take to improve. This stated that they would be compliant with the regulations by July 2017.

At this inspection, we asked the manager about the action plan and compliance with the regulations. She told us, "We would still be work in progress…You can audit things but if you've got no one to improve things, you have to try and do things yourself." She explained that the high use of agency staff meant that care plans and other documentation was not always kept up to date because agency staff did not always see this as part of their role. She explained that she also had to work occasional nursing shifts because agency nurses did not always turn up.

Since 2013, we found the provider was breaching one or more regulations at five of our six inspections. At our previous two inspections in August 2015 and December 2016 we rated the service as requires improvement. At this inspection we found that improvements had not been fully made and identified four breaches of the regulations. This meant that systems were not fully in place or operated effectively to ensure compliance with the regulations and achieve good outcomes for people.

A manager was in post who had applied to register with CQC as a registered manager. She had commenced employment in May 2017. A deputy manager had recently been appointed to support the manager. We noticed that he was mainly based in the dementia care unit. The manager explained that plans were in place to ensure he had managerial oversight of all three units.

We received mixed feedback from people and relatives about the management of the service. Comments included, "She [manager] seems to be doing her best," The manager calls in from time to time, she is very nice, she pops in for a chat," "The home is not well led the manager is too quick to fob us off" and "We haven't seen any improvements since the new manager took over."

We discovered factual inaccuracies with some of the information provided by the manager. The manager told us that a referral to the behavioural support team had been made for one individual. We later found out that a referral had not been made. The manager had documented that they had received a statement from one member of staff regarding a safeguarding allegation. When we asked to see this statement, the manager explained that this had in fact, not been received. The manager told us that weekly meetings were being held with a relative. The relative told us that only one brief meeting had been held. Finally, the manager informed us that one person without any care plans had only been at the home for two weeks. We later identified that the individual had been at the home for a month.

We found shortfalls in certain aspects of the service. This included continued shortfalls relating to medicines, the maintenance of records and training. There was a lack of evidence to demonstrate that certain areas such as complaints and safeguarding incidents were monitored and lessons to be learned

considered to help identify any changes in practice to ensure continuous improvement.

A handover system was in place. There was a variance in the quality of handover records. One handover record contained detailed information; another had no information about people's conditions and needs. Night staff entries had been cut off a third handover record; the reason for this was unknown. There was no evidence that the manager had oversight of handover records. She stated that the staff member who added specific and detailed information to the handover reports was not on duty and they had the information on a computer saving device at home.

There had been a recent behavioural incident involving one person. The manager explained that she had instructed staff to complete behavioural charts. She said that this instruction would have been communicated during handover. We looked at the handover record and there was no mention of the use of behavioural charts. There had been several behavioural incidents on the day of our inspection and there was no evidence of any charts in use. We spoke with a member of staff who had been unaware of the need to complete behavioural charts. They later provided us with a completed chart.

These omissions meant there was a lack of evidence to demonstrate that staff were provided with up to date and accurate information which enabled them to meet people's needs consistently, safely and effectively.

The head of compliance submitted and action plan to the Commission. This stated that on 27 November 2017, they had found there were still issues with the handover documentation because staff were using the incorrect documentation. She also stated that appropriate action had been taken to ensure the safety of all information at the service.

Several people and relatives told us that action was not always taken when they raised concerns or issues. One person told us, "Surveys would be a waste of time, I never went to a meeting, if you ask for something it takes a long time or not at all." Another stated, "We were promised that the company was going to have new flooring, new armchairs and a mini bus to be shared between the other homes and none of this has happened." We spoke with the director of care about the use of a mini bus. She told us that there had been a delay in the purchase of a mini bus because they wanted to make sure that they bought the right mini bus which met people's needs. She said that a mini bus had now been acquired which would be based at the home.

We noted there was no information available at the home to update people and their representatives on action the manager and provider were taking to address the concerns and issues they raised. The last 'residents and relatives'' meeting had been held in August 2017.

Some people and relatives raised concerns about meals and activities provision. One person told us that they would like to be more involved in the service. They said, "I have been to a few meetings I used to help the old manager with staff interviews but not anymore." He told us he would like to take part in staff interviews again. We spoke with the manager about this feedback. She told us, "Again, it's all work in progress, we are trying to set up a residents' association but it takes time."

These shortfalls and omissions constituted a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Following our inspection visits, the head of compliance submitted an action plan, which listed the actions taken to address the concerns we raised.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 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 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always dealt with in line with the provider's complaints procedure. Regulation 16 (1)(2).

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 Systems and processes were not operated effectively to assess, monitor and improve the quality and safety of the service. Records were not always accurate or complete. Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(e)(f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's needs. There were gaps in the provision of training to ensure staff were suitably skilled. Regulation 18 (1)(2).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for people. Action to mitigate risks had not always been carried out in a timely manner and medicines were not always managed safely. Regulation 12 (1)(2)(a)(b)(c)(e)(g).

The enforcement action we took:

We issued a notice of decision to impose conditions upon the provider's registration