Careline Lifestyles (UK) Ltd

Deneside Court

Inspection report

St Joseph's Way Jarrow
Tyne and Wear NE32 4PJ
Tel: 01915191574
Website:www.carelinelifestyles.co.uk

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Ratings

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

Overall summary

We carried out this unannounced inspection over two days, on 21 and 28 January 2015.

At the last inspection we found the provider was not meeting all of the regulations we inspected. We found there were not enough qualified, skilled and experienced staff to meet people's needs, staff did not always receive appropriate training and suitable appraisal and supervision, and the systems the provider had in place to monitor the quality of service people received were not effective or undertaken on a regular basis. An action plan was received from the provider which stated they would meet the legal requirements by 31 December 2014. At this inspection we found improvements had been made and previous breaches of regulations and actions we asked the provider to take had been addressed, however there were two new breaches of regulations identified.

Deneside Court is a 40 bed purpose built home and provides residential and nursing care to adults with learning disabilities and physical and neurological disabilities. It has six separate units with two units on the ground floor, two units on the first floor and another two units on the second floor. Additional facilities include a hydrotherapy pool, kitchen, cafe bar, meeting rooms

Summary of findings

and access to a sensory garden. At the time of our inspection 35 beds were occupied, of which 20 were located on the ground floor and 15 were located on the upper floors.

The home had a registered manager who had been in post since January 2013. 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.

Previously identified breaches of regulations had led to necessary improvements. We found there had been an increase in the number of staff on each shift from the previous inspection in August 2014. A deputy manager had been appointed and would be starting at Deneside Court at the end of February 2015. People at the home, their friends and relatives told us there were some previous occasions when there were not enough staff on duty.

Staff had been receiving regular supervision and appraisals, and the current systems to regularly assess and monitor the quality of services were effective. However additional breaches of the regulations were also identified during the course of this inspection. We found the recording of people's medicines was not managed safely as we found some medicine records were inaccurate and did not support the safe administration of medicines. We also found monthly weight charts had been inconsistently completed, and there were gaps in the risk assessment support plans.

People and their relatives told us staff treated people with kindness. We saw caring interactions between people and staff and there was a friendly atmosphere around the home. People told us they enjoyed the meals at the home although one relative told us that the standard of meals had dropped since the chef was promoted within the company. Recruitment practices at the service were thorough, appropriate and safe. Staff told us morale had improved following the manager's return to the home. All of the staff we spoke with felt the manager was supportive and approachable.

Relatives we spoke with told us, "There have been some issues with my son's care but now I feel the place is on the up." Another relative told us, "Staff are really good with my [relative], which is all that matters". "We have had some concerns in the past but feel confident now the manager is back".

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of this 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. We found that medicines were administered and stored safely, but record keeping around medication administration was not managed safely.

We found staff were recruited appropriately and safely, and there were sufficient numbers of staff allocated to meet people's needs.

Staff knew how to report abuse and were able to explain what abuse was.

The home had personal emergency evacuation plans in place and these were reviewed regularly.

Is the service effective?

Good 

The service was effective. Staff members told us they felt they had sufficient support and training to do their job well.

We saw that staff worked well with other healthcare professionals, and we saw evidence that they closely monitored people's health needs and take action if needed.

The environment was set out to help people stay orientated and find their way around.

Is the service caring?

Good 

The service was caring. Relatives and health professionals we spoke to were confident staff cared for people well. Their comments and our observations provided clear evidence that people were treated with respect and dignity.

Staff interactions with people were kind, considerate and caring.

We saw staff asking people about what they wanted, whether this was about something to do or assistance with. Staff were seen to be friendly helpful and respectful at all times.

Is the service responsive?

Requires improvement 

The service was not always responsive. Although people had their needs assessed and the assessments had been used to develop individual care plans we found monthly weight charts had been inconsistently completed, and there were gaps in the risk assessment support plans.

People received individualised care that met their needs and wishes. They could participate in a range of social activities both in and away from the home.

The service referred people onto other health and care professionals when specific expertise was needed and acted upon any advice.

Summary of findings

Is the service well-led?

Good

The service was well led. Previous breaches of regulations and actions we asked the provider to take at our last inspection had been addressed. The manager was experienced, and staff felt they were listened to.

The provider had quality monitoring systems in place to check that the manger was running the home well. We found the service was operating safely and effectively.

We saw positive and friendly interactions between staff and people who lived at the home. Staff were attentive to people's needs.

Deneside Court

Detailed findings

Background to this inspection

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

This inspection took place on the 21 and 28 January 2015 and was unannounced. Before this inspection we reviewed previous inspection reports and notifications that we had received from the service. We also spoke with a member of the local commissioning team and used the information we gained to plan our inspection.

On the first day of the inspection, two adult social care inspectors were present and we were accompanied by a specialist advisor who had knowledge of people with a learning disability. On the second day of the inspection, one adult social care inspector was present.

During our visit we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven relatives and two health professionals who visit the home on a regular basis. We spoke with nine members of the care staff. We also spoke with the operational compliance manager and the registered manager. We did this to gain their views of the service provided.

We looked at a total of six care records and also looked at five personnel files. We looked at all areas of the home including the lounges, people's rooms and communal bathrooms.

Requires improvement

Is the service safe?

Our findings

People's medicines were not always managed in a safe way. Some medicine records we found were inaccurate and did not support the safe administration of medicines. We viewed a sample of the most recent MARs for the 35 people who used the service. We found that there were gaps in signatures for seven people where staff had not signed the MAR to confirm that some medicines had been administered. We also looked through people's previous MARs and found other gaps in signatures. For example, we looked at two medicine charts for people accommodated on the Keller unit. There were no signatures on the MAR chart for one person's four prescribed medicines on one day. This meant we were unable to confirm whether prescribed medicines had been administered correctly.

One person's MARs chart on Morris unit was not signed as being given on the 19 January 2015. This person was also prescribed an antibiotic that was not signed as being given on that day, and also for two doses on the following day. No corresponding reasons were recorded for this on the MAR chart as to why the drug was not administered.

We also found someone prescribed an anti-psychotic medicine with a total of 18 doses missed, with no reason recorded on the MAR chart. One person was receiving some of their medication covertly following a best interest multi-disciplinary team meeting involving next of kin, GP, consultant neurologist and staff from Deneside Court. The record of staff having read the covert medicines plan had a number of missing signatures.

We discussed our findings with the registered manager and the operations compliance manager. We asked them to tell us about their expectations of staff when there was a gap in a person's medication records. We were told they would expect the staff member administering the next medication to alert them of any gaps. This meant that the gaps in medicines records had not yet been identified and properly investigated. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Qualified nursing staff administer the medicines in the home having undertaken medicines management and administration competency assessments. Each person had a MAR chart which included current prescribed medicines and a record when these were to be administered. At the front of each chart there was a recent photograph of the person, with any known allergy alerts and details on how to support people to take their medicines. Where 'as and when' medicines were prescribed there was a current protocol to follow for each medicine. The care records showed people were asked for their consent regarding administration of medicines.

The medicines were appropriately stored in a locked cabinet for medicines used daily. Liquid medicines in use were labelled and dated when opened. Stock medicines were stored in a separate cupboard secured to the wall. This also contained a suitable further locked internal cupboard for controlled drugs (CDs). No one was prescribed CDs at the time of this inspection.

The drug fridge was located in the same room. The fridge temperatures were not always recorded twice daily as was stated in the medicines policy. This meant staff were not aware if the fridge used to store heat sensitive medicines was functionally correctly.

Relatives comments included, "My daughter needs a lot of looking after, and I have found the staff to be great" and "I have had some issues with the laundering of her clothes and going missing but not so much now". Other relatives told us, "I know he wants to come home, and the staff here all do a good job" and "Staff just know when he is becoming agitated and anxious and try to distract him which seems to work". A member of staff we spoke with told us how the staff call system worked and that staff knew when assistance was needed by someone urgently. They told us there were enough staff on duty which meant they could respond to calls for assistance immediately. We saw this happen in practice with staff responding immediately to an urgent call for assistance. During our visit we noted that staff were available in all parts of the home. One person told us, "I ring the buzzer when I am unwell and they come straightaway. Staff will pop in now and again, but I very rarely need to ring now."

We received a variety of comments about staffing levels at the home. People, their friends and relatives told us there were some occasions when there were not enough staff on duty. They said when this happens they are unable to leave the home without the required amount of supervision staff needed to provide. Four of the nine care staff we spoke to told us there had been previous occasions when staffing levels had been reduced due to staff sickness. Another member of staff said the staffing levels were good, but

Is the service safe?

could go down at the weekend. They commented, "It hasn't been loads of people down, and we still managed. Sometimes it has been due to staff sickness." They confirmed there were 19 care staff on duty every day Monday to Friday, with nine upstairs, and the other staff on the ground floor. A staff member told us, "There have been occasions when we have had 15 staff instead of 19 as people ring in sick. I last worked a weekend two weekends ago, and the staffing levels were fine then."

We discussed staff sickness absence with the registered manager. She did explain some staff had been off work in December 2014 because of diarrhoea and vomiting bug which had also affected some of the people who live at Deneside Court. She said staff try to get replacements but sometimes there had been issues because staff had phoned in sick at short notice. The registered manager then told us about the provider's sickness escalation protocol, where three separate sickness episodes within a 12 month period was being actively managed to ensure all staff were aware of their duties and responsibilities.

Another member of staff confirmed there were two nurses and 19 care staff on duty. Nine staff worked the middle floor, and five staff each on Keller and Morris. She also confirmed one qualified nurse and eight care staff were on duty throughout the night with four of these on the middle floor and two each on Keller and Morris Unit. She also confirmed there were two or three cleaning staff on daily until 4.45pm, a chef in daily with two in on Thursdays. She also confirmed a laundry assistant worked daily plus one administrative worker and a handyman. She confirmed that in the event of staff sickness they can ring other staff to provide cover or ring an agency. The staff member commented, "You can pick up shifts. The nurses know what to do if staff ring in sick. It's a good team working here. If the nurse was absent, I would ring the manager who was on call." This meant people, staff and family members acknowledged previous issues with staffing and how the situation had recently improved with the employment of additional staff.

There was a qualified occupational therapist (OT) on the unit and they told us they were covering from another home two to three days per week depending on needs and prioritises. A newly recruited OT was due to start in post next week who would concentrate on maximising and promoting functional skills of the people. A physiotherapist came to the unit two days per week or as required for urgent need.

One person we spoke with told us, "I feel safe living at Deneside" and "the staff are alright".

We found from viewing other care records that people were routinely assessed against a range of potential risks, such as falls, choking and skin damage. We saw that these had been completed and maintained for each person and corresponding care plans had been developed to help staff maintain people's wellbeing. Where staff had identified a potential risk, a specific person-centred risk assessment had been completed to ensure people were safe. For example, one person had been given the door entry codes to access lower floors independently and we witnessed them use this to go downstairs. The codes had been withheld from another person because staff had identified some risks around their behaviours. We saw from reviewing the records how this was clearly described in a risk assessment and had been implemented due to the risk of them leaving the building without supervision. The members of staff we spoke with were fully aware of these risks and of the need to ensure the person was safe.

We looked at the records for four staff who had recently been employed at the home. These showed that checks had been carried out with the disclosure and barring service (DBS) before they were employed to confirm whether applicants had a criminal record or were barred from working with vulnerable people. In addition, at least two written references including one from the staff member's previous employer were obtained. We saw each staff file had a completed application form detailing their employment history, reasons why their employment had ended and proof of their identity. Documents verifying their identity were also kept on their staff records. A recently recruited member of staff told us they had been interviewed and had a DBS check, and references taken up, including their last employer. They told us "All references and a DBS had to be back, before I could start." This meant the provider operated appropriate and safe recruitment practices.

Staff we spoke with had a good understanding of safeguarding and how to report any concerns they had. Staff told us, and records confirmed that they had completed safeguarding training. One staff member told

Requires improvement

Is the service safe?

us, “I’ve done safeguarding and mental capacity training before Christmas.” They were aware of the safeguarding procedure and said this was displayed in the staff room and main office. If they had any concerns, they said they would, “report to the nurse-in-charge and write and record everything appropriate and sign and date it”. They were aware of the signs of possible abuse and explained people may become quiet and have unexplained bruising.

We found the provider had a system in place to log and escalate any safeguarding concerns. We viewed the log and found concerns had been logged and referred to the local safeguarding authority appropriately. The registered manager told us about a specific example of multi-agency work to keep a particular person safe in which the home had played an important role. This meant the provider and staff understood their responsibilities to safeguard the people who lived there.

Good

Is the service effective?

Our findings

We looked at the training records for three members of staff and saw that they had completed a range of appropriate training, as described by the staff we spoke with. Some staff members had received training in specific areas such as end of life care, understanding dementia and percutaneous endoscopic gastrostomy, (PEG feeding). We saw that staff had access to national vocational qualification training at levels two and three and many had undertaken the requisite assessment and training.

Records we looked at showed that new members of staff had been given induction training at the beginning of their employment. One member of staff told us they had been given induction training and had been tested in each of the subject areas. Their induction comprised of spending time in the training room, going through the policies and procedures. They then spent two days shadowing as an extra member of staff. They then had training in first aid, health and safety, infection control and moving and handling. As a newly recruited member of staff they had not had supervision but knew that it was planned within three months of their start date. They told us, "A senior member of staff is keeping in touch with me and asking how things are going."

All staff on duty communicated with people effectively and used different ways of enhancing that communication either by touch, or ensuring they were at eye level with people who were seated, and altering the tone of their voice appropriately for those who were hard of hearing. We spoke with a member of staff who had a detailed knowledge of people and their needs and wishes. They confirmed they got refresher training every year, particularly in the management of actual or potential aggression (MAPA). They also confirmed they had been given crisis prevention institute training (CPI) which provides training in the safe management of non-violent crisis intervention. A MAPA training event was taking place on the day of inspection. Staff we spoke with at lunchtime told us how they much they were enjoying the course and how they were looking forward in implementing what they had learned.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards exist to ensure people are only deprived of their rights if it is within their best interests. The registered manager understood the homes responsibilities under the Mental Capacity Act 2005 (MCA) and following a recent court ruling regarding DoLS in care settings. Appropriate applications had been made to the authority for consideration under the DoLS requirements for care homes. For example, one person's care records made clear a DoLS authorisation was in place due to the risk of them absconding and putting themselves or others at risk.

A separate file contained all of the DoLs documentation where these had been authorised. The registered manager had clearly recorded authorisation and expiry dates. We spoke with a member of staff who said she had been given training in MCA/DoLS and could explain the importance of respecting people's capacity to make their own decisions and involving family or advocates if they were unable to make their own decisions. We saw that best interest meetings had been held when needed and that they involved appropriate others including families, social workers, GPs, psychiatrists and staff from Deneside Court.

People were supported with their nutritional wellbeing. We looked at six people's care records. We saw nutritional support plans in place which detailed any swallowing difficulties and dietary requirements such as 'soft' foods and thickened fluids. The records also described people's personal preferences, such as 'insists on egg and chips every day'. We spoke with one person who told us, "Staff are just brilliant, and they come up with my meal at lunchtime and at teatime". "Staff know what I want, I want egg and chips every day". "It suits me down to the ground." They told us "I rarely need to see a doctor but get support to have my toe nails attended to". A member of staff confirmed they were aware this person had a swallowing problem, and the care plan confirmed that the NHS dysphagia service had been involved.

Another person told us, "I've lost weight but I'm not underweight." The registered manager said the occupational therapist had worked with this person about supporting them to purchase and make their own meals, which they confirmed. We saw they had a nutritional care plan which showed they were being helped to make their own drinks and breakfast. They were asked about choices for other meals but thought this should be done the day before, not the same day. During the serving of lunch we used the Short Observational Framework for Inspection (SOFI). We saw positive and caring interactions between

Good

Is the service effective?

people and staff. We noted how people were being supported to eat, drink and to express their preferences. For example, staff were observed offering alternatives to the choice of different courses at lunchtime.

Detailed behaviour support guidelines were in place regarding risks. The risk assessments referred to staff training in MAPA if someone attempted to assault staff. The risk assessments clearly explained interventions staff should use such as CPI or MAPA block techniques and move to a safe area. If the behaviour continued, staff were instructed to use 'interim control positions' until more staff could assist.

The current occupational therapist had been working closely with a behaviour co-ordinator and a behaviour analyst. They had been collecting quantitative and qualitative data to inform baseline behaviours to identify triggers and develop positive behaviour support plans. The support plans used proactive strategies that avoid and minimise the use for physical interventions. The approach involved observing staff during interventions and feeding back to them about how there interventions or non-verbal behaviour may have worked well or may have triggered a negative behavioural response. For example, it was evident from one person's care records that progress had been made with them since their admission. The person required a significant amount of one-to-one staffing input when they were first admitted about two months previously. Now they were able to spend time alone in their flat. The care plan had been reviewed with the person and their care manager, which confirmed the level of support had been reviewed and reduced due to this progress.

We saw evidence that people's plans and assessments were changed over time as people needs changed. There was evidence that other professionals were involved in the planning and routine care of people. These included occupational therapy, dietician, GP, practice nurse, physiotherapist, dentist and optician. We spoke with two nurses from the acute care team who were visiting. They told us they had no concerns regarding the care and treatment people were receiving at Deneside Court and that how all referrals from staff for additional input had been appropriate.

Good

Is the service caring?

Our findings

People who used the service and their relatives gave us feedback about the care provided. One person told us, "The staff are lovely and I could not imagine any better place to be". "The care here is wonderful." A relative commented, "How impressed I have been with the trouble that has been taken to make my [relative] comfortable". However one person told us, "I wish they would keep his weekly activity planner up to date, as it helps us as a family know if he is in or out somewhere."

People were supported to be independent and make their own choices where abilities allowed. On the Morris unit we saw how staff were encouraging people to make their own breakfast and beverages. One person told us, "I make my own breakfast every day and I like the choice we have of different cereals to choose from".

The single bedrooms had the doors personalised to assist with orientation and promoted independence and a sense of personal space. The bedrooms were further personalised with people's own belongings and pictures of family and friends and recent events as appropriate. The senior care worker who was showing us around the unit told us, "People are encouraged to choose their own colour schemes or supported to do so." All of the bedrooms we visited were clean and in good decorative order. Staff members we spoke with demonstrated a good knowledge of people across the service and their needs. All units had clearly displayed the services complaints procedure. Staff were seen to be kind and caring and knew people well.

The care plans we looked at were seen to be personalised and referred to people's privacy and dignity needs. For example, one person did not like the staff to see them undressed and this was recorded in their care plan. The plans also noted where people may get distressed or worried about things. A member of staff we spoke with also emphasised the importance of respecting people's beliefs and the way they wished to live their life. Interactions of the various staff on duty throughout the course of our visit were seen to be caring, responsive and respectful. We saw how staff knocked on bedroom doors and waited before entering and were mindful of people's privacy if they required help with personal care. One person told us, "They're as good as gold, that way." They confirmed they could choose when he got up and went to bed. The person commented, "I get up late, and stay up late". "They're very caring." He had a key to lock his bedroom door, which he used. He confirmed he could receive visitors in his room, including his family's pet dog, which they enjoyed.

Another person told us how they participated in a range of social activities, such as visits to Newcastle and Durham. "If I want to go out, I mention it to staff and they sort it out". "They don't refuse." They later told us, "The staff are nice, and I am able to make choices about my daily life." The care records for this person showed the provider's occupational therapist had worked with them about identifying the activities they would enjoy pursuing.

We heard staff explaining to people who required assistance what they were intending to do, and to others about the times of any planned external activities or appointments in a patient and appropriate manner. From the care records we looked at each person had an activities programme and staff were heard and observed to enquire as to whether that was still what they wanted to do or would they like to do something else. This meant people were offered choices and were encouraged to make their own decisions.

We spoke with the registered manager regarding whether anyone was currently using any advocacy services. An advocacy service ensures that vulnerable people have their views and wishes considered when decisions were being made about their lives. The registered manager told us only one person was currently using the services of an advocate, and how this had been arranged while the person was in hospital.

The registered manager told us, and records confirmed that meetings for people using the home and relatives were held every two months. We saw topics discussed in the December 2014 and January 2015. These included staff sickness levels and updates from the most recent management report. Relatives we spoke with told us they were kept informed by the registered manager and staff about their family member's health and the care they received. One relative said, "I'm kept up to date which is all I ask."

Requires improvement

Is the service responsive?

Our findings

We spoke to one relative on the first day of our visit who expressed some concerns regarding their relatives care. Their concerns related to other people's clothing being placed in their relative's room, planned weekly sessions in the indoor swimming pool not taking place, and activities away from the home not happening. They told us, "Staff just do not understand my [relative] has certain routines which they need to be reminded of." We discussed their concerns with the registered manager. They agreed to meet with the relative and at our next visit, a week later, they told us significant improvements had been made. Another relative told us, "The laundry is fine when x [member of staff] is working in there. It goes wrong when she is not there. I have started taking my daughter's dirty clothing away with me to wash separately."

Another relative showed us his daughter's bedroom. They explained they had asked staff the previous day before to empty the waste pedal bin. We saw this had not been done and was now full. We were also told how their relative's nurse call system and the remote control for the television were not within the persons reach when they visited them. Other than these little things they told us "I do not doubt the staff look after her". Another relative told us. "I know she needs a lot of attention, and the staff are really good with my [relative]". "The only issue we have is with the laundry, although things have improved since x was employed we still take my mam's dirty laundry home with us."

The registered manager told us that they were currently in the process of transferring people's records over to a new style record system and there was an action plan to systematically complete the transfer. Some of the records we examined during the inspection were still on the old style system which made accessing salient information difficult.

We looked at a total of six care plans, which reflected people's views, interests and contained important information about the person and their background history. Care plans identified people's spiritual and cultural needs and wishes. Pre-admission assessments had been carried out. Information had been gathered from previous placements and significant information.

The care records consisted of three elements which included support plan/risk assessments, daily activities record folder and a weight charts folder. Monthly weight charts were found to be have been inconsistently completed. Written instructions to staff on the triggers for weight loss and gain were not completed on every chart. For example, one person's chart stated the trigger for action by staff was a weight gain or loss of three kilograms or more. However the person had gained eight kilograms during November 2014, but there were no written instructions to indicate that this was reported and what, if any, action had been taken. This person also required their blood pressure to be monitored monthly. There was no chart to confirm this was being done and the nurse in charge told us there was no chart.

In other care records we saw how two people had not had their weight recorded since September 2014 and another since October 2014. Many of the entries we saw did not have a signature against the entry. This meant by not under taking basic wellness assessments as indicated in people's care plans any early fluctuations/indicators in a person's wellbeing could be missed and an opportunity of early intervention and action being taken delayed.

For another person we saw they had been resident at the home since June 2014. We saw support plans and corresponding risk assessments for identified needs. However their recreation and occupation support plans had not been reviewed since admission and their spirituality and cultural support plan dated August 2013 was documented as "Refused to participate in this". We saw no further reference to indicate that this had been revisited. This person had also been assessed as a high falls risk. The last risk assessment was dated 26 January 2014. It was recorded that this was reviewed on the 30 December 2014 but no evidence that the risk was re-assessed as part of this review. This was a breach of Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records.

Other care plans we looked at were personalised. They had been reviewed monthly. One showed that the in-house occupational therapist (OT) had provided support to one person to help them get out in the community with staff assistance. The OT had identified with the person their particular areas of interest, such as playing golf and walking. A newly recruited member of staff confirmed this person went out nearly every day with staff, depending on his choice, to the shops, Durham or Newcastle.

We observed staff spending one-to-one time with people. For instance, a member of staff was reading to one person

Requires improvement

Is the service responsive?

in their bedroom and another person was doing a jigsaw with a member of staff. We noted one person was happily singing and dancing. There were facilities such as a dart board and pool table for people to use. One person told us they enjoyed going to football matches.

We observed how another person mentioned he would like to have a shower. A member of staff responded positively and said this would be no problem and asked another care worker to support the person with this task.

Another person told us, "There is nothing to do here. I just watch telly." However, they said staff did offer support to go out but they refuse as they can't walk far. When we asked about using a wheelchair, they said, "No, it's alright." The persons care plan identified that this person was not well motivated to go out and was being encouraged to take short walks with staff to build up their stamina. A newly recruited member of staff confirmed people do go out on regular walks with staff.

People and family members told us they were aware of the complaints procedure and knew how to complain. The complaints procedure was displayed prominently and used signs and symbols to help people understand it. People we spoke with were aware of how to make a complaint and also aware of CQC. We spoke with the registered manager of the service about any recent complaints which had been resolved. She told us she was supported by the company's human resource department when investigating and responding to complaints. She confirmed they do not have any current active complaints and all previous actions had been completed.

Good

Is the service well-led?

Our findings

The staff we spoke to at the home told us they liked working at the home because they enjoyed working with the people who lived there and enjoyed working with their colleagues. When asked how they felt they were supported by the registered manager, they told us, “We get on with the manager, she’s very supportive regarding shifts and flexibility” and “No problems and if I had a problem I would go straight the manager”.

One of the senior care workers told us the registered manager was” very approachable” and that a new deputy manager would be starting soon. They also confirmed that the service was visited regularly by the operational compliance manager and commented, “She’s dead nice. She talks to you and asks you how things are going.” We asked staff what was working well at the home, and they told us “training”. One staff member commented, “We have had loads of training courses to attend recently, and we don’t mind.” A newly recruited member of staff said the service was “managed well”. They had not actually spent any time with the registered manager but had no problems regarding the way the service was managed. They further described the staff as “a good working team”.

The home kept records of any accidents and incidents. The registered manager said they acted upon analysis of accidents and incidents. For example one person had their observation levels increased following an increase in the number of occasions they had fallen. We saw auditing systems were in place and referred to as “periodic service reviews”. The majority of these were carried out by the operational compliance manager and checked such areas as care plans, infection control, medication checks, and health and safety. We saw examples of such reviews carried out in January 2015. Each completed audit came with an action plan identifying who was the responsible person and when any actions would be completed by. These were carried out at regular intervals and meant that the manager was making sure various systems within the home were being checked and continuous improvements being made.

Local commissioners of the service told us that their most recent ‘quality standards’ assessment of the home had identified some continuing areas for action. The commissioners said they had revisited the service to validate the action plan submitted by the provider, and improvements had been made regarding an increase in staffing numbers, staff supervisions had increased along with safeguarding training and medicines training. We saw records that showed the registered manager held regular team meetings that showed staff were given information and advice and also encouraged to contribute to the running of the home. The content of those meetings was being monitored by the provider.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with medicines because the provider did not have accurate records to support and evidence the safe administration of medicines. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. Regulation 20 (1) (a)