Lifeways Community Care Limited

Elswick Hall Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 4, 5 and 8 June 2018 and was unannounced on the first day, which meant the provider did not know we were visiting. This was the first inspection since the service registered with the new provider in May 2017.

Elswick Hall Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Elswick Hall Care Home is registered to provide accommodation for up to 47 people with residential and nursing care needs. Some of the people who lived at the service had complex needs, including those who were living with dementia and people with severe brain injuries. At the time of the inspection, there were 23 people living at the service. The service only had 45 bedrooms and the provider was in the process of arranging to update their registration.

The service did not have a registered manager. A new manager had recently commenced employment at the service in April 2018. 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.

A new management team were in place and were working hard to address the issues we had found during our inspection, some of which the provider was already aware of.

Medicines were not managed appropriately at the service. For example, thickeners were stored insecurely in dining areas. Thickeners are used to support people who have swallowing difficulties. However, they can pose a danger to people if consumed inappropriately. Some medicines lacked detail on how staff should administer them and medicine records were not always fully completed.

People had not always had pre-assessments completed before they moved into the service. Risk assessments, care plans and other associated documentation needed to fully support staff to meet people's needs were either not in place or not fully completed. The new management team were in the process of rewriting every person's care records, including those in connection with people's capacity. Due to the nature of the service, we would expect to have seen a number of accidents and incidents involving the people living at the service. However, not all records were available and we were only able to see one recent accident. This meant that we could not be sure accidents and incidents were recorded and dealt with appropriately.

The provider supported people with their finances, although no care plans or risk assessments were in place and we found considerable amounts of money for two people held within the company's bank accounts

rather than in the bank accounts of the individuals concerned.

Checks on people's pressure relieving mattresses did not happen regularly and we found people's mattresses were not always set correctly. This meant people were put at further risk of pressure damage.

We found some issues with infection control, including kitchen staff not having suitable changing facilities. The provider had been in touch with the infection control lead for care homes to support them in any improvements needed and intended to address issues highlighted, including via refurbishment work planned.

Fire drills had not been completed as often as they should have been, although the provider rectified this during our inspection. Some actions on the fire risk assessment were outstanding and the provider was in the process of addressing these.

On arrival at the inspection, we found only one member of staff on duty on the upper levels of the service for the people living there. Some people required two staff to support them. The provider recognised at the same time that this was unsafe and asked another member of staff to work in that area.

There were safe recruitment procedures in place and staff were checked prior to starting work to ensure they were suitable for their role and safe to work with vulnerable people. Staff told us they were much better supported than previously and said they were happy with the training they now received. We did see gaps in support sessions and training which the provider was aware of and were working to address.

Staff were aware of their safeguarding responsibilities and told us they would report anything of concern. People told us they felt safe living at the service and relatives thought that their family members were safe too.

People were not always supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service were not always being followed. Staff had not always sought ways to offer people choice of meals for example, particularly those people who could not always communicate. People's care records did not always reflect people's capacity and decisions made in their best interests.

People told us they generally enjoyed the food prepared for them. There was a varied weekly menu. Although kitchen records were not up to date with people's special dietary needs, we saw that people received the correctly prepared nutrition to correspond with their needs.

Arrangements were made for people to see their GP and other healthcare professionals when they needed to.

Many of the staff we spoke with had a caring nature and treated people with dignity and respect. A number of staff were about to complete a charity bike ride to raise money for people's activities and outings. However, we found elements of an uncaring culture within the service. A number of staff had been recently suspended or dismissed due to not following correct care procedures. Minutes of previous staff meetings indicated conduct from some staff which was not conducive of a caring environment. The new management team had been very proactive in addressing these concerns with current staff.

Activities were available for people to participate in and some people were happy with these. However, not all people received the type of stimulating activity which was more suited to their particular needs, including

for example, those people living with dementia. We spoke with the provider about this and they agreed that this needed to be addressed.

Information on how to make a complaint was available to people at the service and to relatives and visitors alike. Not all records of complaints were available to confirm they had been dealt with effectively.

People were now encouraged to make their views known and the service supported this by holding meetings and asking for feedback in a number of ways, including suggestion boxes, and completing surveys.

Audits and checks had not always been completed. The new management team were in the process of implementing a range of audits, including those in connection with medicines and infection control.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to safe care and treatment and good governance.

We have also made six recommendations in relation to staff induction, supporting people to make their own choices, peoples finances, activities, complaints and the format of people and relative meetings.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not managed safely. Risk assessments were not always up to date and records of incidents were not all available as they should have been.

People's finances needed to be reviewed to ensure they followed best practice.

Infection control procedures needed to be followed fully.

Staff were aware of their safeguarding responsibilities and knew what to do if they had any concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always assessed before moving into the service to ensure their needs could be met.

Staff were trained and supported and the provider was working to address any gaps in these processes.

The manager understood their role in connection with the Mental Capacity Act 2005 and of the Deprivation of Liberty Safeguards and they worked within legal guidelines. Best interest decisions and recording in connection with people's capacity were not always recorded.

People were supported to eat a range of different foods, depending on their needs. However, staff had not always tried methods to allow people to choose meals themselves.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff we spoke with showed caring attitudes. However, this was not the case for all staff and a number of staff had been suspended or dismissed due to their lack of care.

People were seen to be treated with dignity and their privacy maintained. Independence was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had not always received care which was person centred. Care records were not always in place or completed fully.

Activities were provided and enjoyed by some people but review was needed for some people to ensure they received suitable stimulation.

The provider's complaints procedure was displayed around the service and people and their relatives were aware of how to complain if they needed to.

Is the service well-led?

Requires Improvement

The service was not well led.

A registered manager was not in place. A new manager and senior management team had recently been appointed and staff and families thought they were now working well to improve the service.

The provider had an overall quality assurance system, but it had not always been followed. The provider had taken over the service in May 2017 and had not yet fully addressed record keeping issues.

Meetings and/or surveys had been held for people and their families to allow them a way to feedback about the running of the service.

Elswick Hall 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.

This inspection took place on 4 and 5 June 2018. The first day of the inspection was unannounced which meant the provider did not know we would be visiting. The second day of inspection was announced so the provider knew we would be returning. The inspection was carried out by one adult social care inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was used to support the planning and the inspection process.

We reviewed information we held about the service, including statutory notifications we had received from the provider about deaths, safeguarding concerns or serious injuries. Notifications are incidents which the provider is legally obliged to send the Commission. We contacted the local authority commissioners and safeguarding teams and the local Healthwatch team. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services.

We contacted the infection control lead for care homes, the fire service, tissue viability nurse specialist, nutrition team, the local authority DoLS (Deprivation of Liberty Safeguards) team, palliative care teams, advocate services and local pharmacists. We used any information received to support our planning and judgements.

During this inspection we carried out observations using 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 six people who used the service and four family members. We also spoke with the clinical service area manager, the head of health and clinical governance, the quality manager, the manager, the

service administrator, the maintenance person, one nurse, three agency nurses, three team leaders, six care staff, two cooks, one activity coordinator and one kitchen assistant. We also spoke with two staff employed at a nearby service who had been asked to support the service. We observed how staff interacted with people and looked at a range of records which included the care records for five people and medicines records for 22 people. We looked at five staff personnel files, health and safety information and other documents related to the management of the service.

We placed a poster in the reception area to inform visitors of our inspection and asking for feedback about the service.

Inadequate

Is the service safe?

Our findings

Medicines were not managed safely. 'As required' medicine protocols were not in place. 'As required' medicines are those that are required as the need arises, for example, for pain relief or constipation. It is important that these are in place, particularly for those people who are unable to communicate their needs. During the inspection the provider worked to put these in place and ensure they were up to date.

Medicine administration records were not always completed fully, with gaps, scribbles and missing instructions for administration from the pharmacy. For example, one person's transdermal patch application record had not been marked as being applied or the previous one removed which can lead to missed medicines or an overdose situation. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medicine through the skin into the bloodstream. Medicines lists on people's records were out of date as medicines had changed.

Topical medicines were not always recorded as having been applied. However, staff confirmed they had completed these tasks and the provider had placed new topical recording sheets in place during our inspection. Topical medicines are prescribed creams and ointments used on the skin.

Cartons of thickeners were stored in dining areas insecurely. Thickeners are usually powders added to foods and liquids to bring them to the right consistency/texture for people with swallowing difficulties. A warning was issued in 2015 to care homes to ensure these products were never left unattended as a person had died due to swallowing this substance. We informed the provider immediately and the products were removed and placed in secure storage. We also saw that staff used one person's prescribed thickener for several people which is not good practice.

One of the medicine rooms was being used as an office and to store people's records and all staff had the code for entry. Good practice dictates that medicine rooms should be used only for medicines and related equipment. During the inspection, the provider relocated the downstairs staff office within the medicines room and were in the process of fully setting up the new location.

Medicine risk assessments had not always been completed. One person who administered their own medicines needed a medicines risk assessment in place to keep them safe, but this had not been completed and the provider acknowledged this.

Pressure relieving mattresses were not always set correctly. For example, one person who was at risk of pressure damage had a pressure relieving mattress which was set to accommodate a person who weighed 80kg when the person only weighed just over 55kg.

We checked people's records to confirm if details of the settings were included in their care plans and found there was no information about what settings mattresses should be on which placed people at risk of pressure damage. We brought this to the attention of the provider who said they would look into this straight away. The provider also informed us they were about to put in place mattress audits, which we were

shown and which would reduce the risk of this occurring in the future. The provider also confirmed they would contact the tissue viability team to arrange a visit to support the service further.

Risk assessments were not always in place or up to date. For example, one person's eating and drinking 'screen tool' stated a pureed diet should be in place while their risk assessment for choking indicated a fork mashable diet. The provider was in the process of reviewing all records. We also found the legionella risk assessment had not been reviewed since 2016. The provider confirmed that they were arranging to have one take place in the next few weeks.

Accidents and incidents had been recorded. We would expect to see a number of accidents or incidents over a period of time, due to the complex needs of people living at the service. However, we were unable to view any prior to the current manager starting employment. We were told there had been some IT issue with previous management. At the time of the inspection, although there had been only one accident we were told there was no analysis completed within the service. We were told by the clinical area manager that in future this would be monitored by the provider during checks of the service data provided by the manager. We could not be assured that historical accidents or incidents had been dealt with correctly because of a lack of information.

We found foods stored in dining areas had not been dated or labelled. For example, what looked like cornflakes and some other breakfast cereals. It is important that foods are labelled fully and dated with the use by date to ensure that they are used in good time and that staff can ensure any person with allergies are not given the incorrect food by accident. We brought this to the attention of the provider who acknowledged this should not have happened.

These are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment.

We checked the finances of people living at the service. The provider was the appointee for two people who had excessive amounts of money in the providers bank accounts. Appointees are people who have been empowered by the owner of property/money to decide the disposition of that property/money. However, we saw no evidence to suggest this was the case. Although the money was all accounted for, it was not appropriate for the provider to be appointee and these two people should have been referred to the court of protection as there was no family involvement. The provider also confirmed they felt this arrangement was not appropriate and said they would look into it. We informed the local authority about this, who confirmed they would look into this matter. The local authority later confirmed that they were happy with the financial arrangements at the service.

We recommend the provider consider current guidance on supporting people with their finances and take action to update their practice and policies accordingly.

A number of staff we spoke with told us that the previous management had not listened to their concerns about staff not fully performing in their roles. Staff now told us they felt confident in the current management team and said the current manager listened and had acted on any issues they had raised.

A fire risk assessment had been completed in September 2017. There was only one action remaining which had been identified. This was to provide a suitable exit from the lower ground training room which would allow people with mobility issues or other impairments to easily exit via the garden area. The provider confirmed that this was to be completed as part of the refurbishment process. We noticed some gaps on the bottom of some people's bedroom doors (fire doors). We passed this information over to the fire authority

who said they would bring forward their fire safety audit to check, although felt there was no immediate danger. The provider also looked into this issue and told us a full review was taking place on 22 June.

We noticed that fire drills had not been completed at the service since September 2017. Drills should be completed as a minimum every six months. We spoke with the provider about this and before the inspection visits were completed a drill had taken place with plans for further drills in the coming days. Fire safety training for staff had been completed, exits were clear and clutter free and fire extinguishers were in place and had been maintained correctly. People's emergency evacuation plans (PEEPs) were in place to support emergency services to evacuate the building should the need arise.

The premises and equipment had been maintained. A recent five year mains electric check had been undertaken and we spoke with the contractor who confirmed this and said the certificate would be sent out soon. All remedial work had been completed to make the service satisfactory and they showed us an example of some of the electrical work undertaken. Gas safety and lifting equipment checks had been undertaken. Portable appliance testing had recently taken place and we saw evidence by way of stickers on people's personal appliances, for example, in their bedrooms.

We found there were not enough staff on duty on the upper levels of the home during the first day of inspection. The provider had also recognised this on the same day and placed another staff member in this area. We looked at staff rotas and the calculations used to ensure enough staff were available and found they now were. One relative we spoke with said, "Yes, there are enough staff." The same relative told us that some staff worked better than others and there had been a culture of laziness but that this had somewhat improved since the new manager started work at the service. Another relative told us, "I think there is enough staff but I am starting to wonder about a weekend as things don't seem the same." The provider was in the process of reviewing all staffing hours to ensure that enough staff were on duty at all times.

The service was generally clean and tidy. We noticed that dirty laundry was stored in unsuitable containers. However, we saw evidence that new containers had been ordered and were due delivery. We did see two examples of staff not using person protective equipment appropriately, for example, not changing gloves after providing personal care to one person and then continuing into another person's room. We told the provider about this and they said it would be addressed with staff. We also saw that staff, including kitchen staff had no place to change their clothes. Some areas of the home were still in need of renovation to maintain infection control standards. The provider said they were looking into this as part of their refurbishment. We spoke to the local infection control lead for care homes as they had recently been to visit the service and provide support. They told us they were impressed with the responsiveness of the manager and said, "Manager was engaging. It was all very good."

People told us they felt safe and their family members told us they felt the same. Staff appeared to have a good understanding of their role in connection with keeping people safe. One staff member confirmed that they had recently raised concerns with management who had been quick to act on them. One person told us, "I have no problems living here. I feel safe and staff help me. Never any trouble, it's a quite area too." Another person, "Oh yes pet, I am well looked after and have no complaints." One relative said, "Yes [person] is safe." Staff had undergone safeguarding training, but some needed a refresh and this had been booked to take place in the next few weeks. We were confident that any issues raised would be dealt with thoroughly by the current management team.

The provider had recruitment procedures in place. We reviewed the personnel and recruitment files for five staff. Records held application forms, evidence of qualifications, interview notes, eligibility to work in the UK documentation, Disclosure and Barring Service checks (DBS), two references and nurse pin numbers. The

DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. All nurses and midwives who practise in the UK must be on the Nursing and Midwifery Council (NMC) register and are given a unique identifying number called a PIN. Nurse PIN numbers were monitored to ensure they remained valid and up to date. We noted that one agency worker's profile was marked that their CRB check had been completed. CRB was the Criminal Records Bureau which ceased to exist in 2012 and this possibly indicated a regular review of this person's suitability to be employed may not have been completed. We raised this with the provider who said they would look into this.

Requires Improvement

Is the service effective?

Our findings

The provider had not always ensured staff had sufficient guidelines and information to meet people's health needs consistently. Care records did not always contain pre-admission documentation. One person's care record had care plans in place which were not all complete or accurate and there was no pre-assessment completed. Pre-assessments are important documents which ensure that the service is able to meet the potential needs of people before they move in.

Care plans were in place for people to meet any identified need, for example in relation to medicines, mobility, nutrition, cognition or hygiene. We found, however, that records we reviewed were not always completed fully with information missing or inaccurate. For example, there were no financial care plans in place for the people who required support with their personal money's. One person's actions from time to time, we were told, may have challenged staff, including the potential for physical injury. This detail was not documented in their care records. Although recording was an issue, we saw no evidence to suggest that people's needs had not been met.

The new management team had recognised these shortfalls and had started the process of reviewing every person's care records in the service and implementing new paperwork.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to good governance.

Nursing staff conducted a handover session at all shift changes to all staff on duty. We observed one taking place. Some staff did not pay full attention to the verbal handover as they chatted quietly to others about unrelated matters. The agency nurse completing the handover was unaware of the health concern in relation to one person who had seen a GP the day before and a member of staff had to remind them. The handover was verbal, but there was a written format in place also. We were given a copy of a handover sheet and one person who was no longer living at the service was still on this. Although a new handover process was being implemented, we deemed the current process was not robust. The provider was given our feedback to act on.

One relative felt staff had not always communicated with them as well as they should have. For example, they told us their family member had been prescribed a different medicine and they had not been made aware of why that was. Another relative was complimentary about the communication and said, "I am kept well up to date about any issues. There was [described a health issue] and was really kept involved."

Staff, including agency staff, received an induction into the service. We checked the induction records of agency staff and found that it covered all the main points of working within the service, including a walk around and meeting with the people who lived there, how care was recorded and fire and first aid arrangements. However, when we spoke to one agency nurse, they told us their induction had not been as robust as it should have been and although they were given an overview of the service and the people living there, they said it should have included more in-depth information and time allocated to review this

information.

We recommend the provider review its induction procedures in line with best practice.

Staff we spoke with said they were very happy with the training which had been recently carried out and one staff member said, "Training is much better face to face than the on line training we had before. I have learnt a lot." We checked staff files and found training certificates in a number of subjects, including food hygiene, moving and handling and emergency first aid. The service administrator provided us with an up to date list of training completed and those booked for a near future date. The list showed that most staff had received recent refresher training and more training was planned. We noted that some future training was yet to be planned. The provider told us that all training was being reviewed to ensure all staff were up to date.

Staff supervision (staff support) sessions had taken place and staff had received a yearly appraisal of their work. We did find some gaps, but we saw evidence that the manager was working their way through these and had made good efforts to bring them up to date. Staff told us they felt much more supported by the new manager.

The manager was aware of their responsibilities and had followed correct procedures regarding the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure 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. 11 people were subject to a DoLS which had been applied for and authorised (or awaiting approval) via the local authority and this was confirmed by the local authority. These were all in order and monitored.

People's capacity had not always been considered, although when we arrived for the inspection, staff were busy addressing this by reviewing care records. Staff were also reviewing and updating any best interest decisions which may have been required, to ensure documentation was in place to show who had been involved. When we looked at some of the updated records, we found that one person had a best interest decision made for a particular decision but only staff had been included in the decision and no healthcare professionals or relatives etc. The process of making best interest decisions can be a lengthy procedure as providers need to ensure appropriate parties are involved. We spoke with relatives about any decisions that may have been made and they said that they had been included. This was not always documented. We also saw other documentation in people records to show that other healthcare professionals had been involved, but this was not recorded in a way which made it clear this had occurred, including the use of the best interest records the provider normally used.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to good governance.

We overheard staff asking people for consent. One staff member asked a person if they wanted help with a particular task and received a nod for yes before they started to help. We overheard two different nurses who were administrating medicines to people, asking for consent before they supported people to take them.

People were generally complimentary about the food they were served. Comments included, "The food is canny (nice), yes, it's okay"; "It's okay" and "It's alright. I get plenty." A number of people received their food via a PEG. A PEG is a medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. We spoke with a dietitian from the Home Enteral Feeding Team who visited the service. We asked if there were any issues with procedures at the services and they said, "The staff follow the guidance we give them and its kept in bedrooms." We asked relatives their views of those people who received food via a PEG. One relative told us, "Manage super, regularly monitored." Another relative said, "Think it is okay. Some issues before and they apologised."

Kitchen records were not up to date and included misleading information about people's dietary needs. For example, one person had recorded on the meal planner list that the person was normal diet, yet on other information held in the kitchen, it stated the person was diabetic. Another person was recorded on the meal planner list as requiring a soft diet, while information from the Speech and Language Therapy Team indicated they were on a pureed diet. We discussed this with the provider who immediately asked a member of staff to update the records and we saw this taking place. Although records were not always accurate, we found people had received the meals they should have.

People were not always provided with suitable ways to decide what they wanted to choose to eat the next day. Staff asked people the night before what they would prefer for meals on the following day from the choice available. We asked staff how they managed this for people who could not communicate. One staff member told us, "We know what they like and don't like to be honest, so we pick something we know they will like. If they don't like it, we will try something else." Staff told us they used to use picture cards to support people to choose, but this did not happen at the moment. We also noted that no menu list was placed on the boards in the dining room, which meant there was no reminder of what meal choices there was for any particular day.

We recommend the provider utilise best practice in supporting people to choose what they prefer themselves where ever possible.

We observed the dining experience at lunch time. Although the atmosphere was quiet with little conversation, staff attended to the needs of the people within the dining room. This included support with eating and drinking. A number of people remained independent due to the additional measures put in place, for example plate guards. Plate guards give additional support to people who, for example, only have the use of one hand or those people lacking in dexterity.

People had access to health care professionals, including geriatricians from the older people's Belsay unit (specialist unit for older people in the area), GP's and hospital specialists when the need arose. One relative explained that a number of professionals were currently involved with their family member. A number of people had previously been referred to the speech and language team (SALT) to support them with swallowing difficulties.

The property was suitable for wheelchair access. Ramps and accessible lifts were available to support people with mobility needs to move around the service. The provider was in the process of some refurbishment work. We saw that some rooms had been decorated but more work was required and work to make the garden area more accessible was needed too. The provider had completed other work to improve the building, including installing new sluice facilities. People's bedrooms had been personalised and one person told us they had chosen the colour of the paint and soft furnishings. They said, "It's my favourite colour." There were spaces for people to meet with visitors should they so wish, including lounge areas.

There was an area at the rear of the building which people used to smoke and we noted a smoking shelter also in place nearby. We found, however, that one area was right outside people's bedrooms and we saw smoke at times drifting in that direction. There was no risk assessment in place and we saw no evidence to suggest people had agreed. We spoke with the provider about this who said they would look into this.

Requires Improvement

Is the service caring?

Our findings

Comments in some older staff meeting minutes indicated inappropriate behaviour by staff and previous management. For example, it was recorded, "Tell him (service user) to go to his room"; "I have contacted social worker to place him elsewhere, you need to take control." We were also made aware of recent incidents involving a number of staff which had led to suspension from duty and dismissal. Another set of minutes stated, 'Mobile phones not to be used, needs to stop now, now seen too many staff openly using them in lounges etc. (This indicating staff were not supporting people as they should).

In minutes it was noted that feedback from the previous meeting was discussed. We saw that two separate meetings four months apart had feedback of a similar nature. This alluded to staff not following instructions and continuing, for example, to swap shifts without authorisation. Sickness levels at one point was recorded as, 'Shocking' with some staff ringing the service five minutes before their shift was due to start to say they were unwell.

One relative told us, "Sometimes carers are just sitting and not checking as they should. I saw one person [care staff] filling in records but they had not done anything I had seen." Another relative told us, "I think the staff have been rattled. They have had their own way for too long." The provider had told us some staff had not been providing people with appropriate care and treatment, but this had been addressed and reported to the appropriate authorities. Although we did not witness any inappropriate behaviour or actions, this information is not conducive to a caring environment.

Other comments from people and relatives showed that not all staff were uncaring. Comments included, "They [all staff] are canny, well I get on with them"; "Nice girls"; "They have been excellent to me"; "Most of the staff are really nice"; "They (care staff) volunteer to go to the theatre on their day off" and "I would say staff on the whole are good."

Kitchen staff made a cake for people when it was their birthday and one person told us, "Ha, they sing happy birthday to everyone when they bring out the cake. I think the kitchen have a list of everyone's birthday."

We were made aware that a number of staff were about to undertake a bicycle ride in aid of the 'residents fund'. One staff member said, "Staff are always doing something like this to help raise money to spend on people and activities. We have been able to buy all sorts of things."

One staff member told us they loved their job and said, "I love the people who live here and I would do anything for them. I have known some of them for a long time…they are great." Another staff member said, "It's good that they [staff involved with recent incidents] have been dealt with, gives everyone else a bad name when that happens as we can all get tarred with the same brush."

We observed staff talking to people about things that were important to them. One person had recently received an upgrade with their Sky subscription and staff were heard discussion what the person enjoyed watching and which programmes they were going to watch first. The staff member clearly knew the person

well as they knew which programmes the person liked and when they preferred to watch them.

We saw non care staff showing kindness to people. As we walked around the service with one member of staff a person asked them if they could have a drink. The staff member responded immediately, telling the person that they would go and get someone to help them. They then went to seek a member of care staff and asked them to support the person with some refreshments. They came back and apologised for leaving us. This showed that they had their priorities in order, which was the care of the people living in the service.

People's privacy and dignity was valued and protected. We saw that people had a key to their own room if they so wished and staff were only allowed to enter without the person's consent (one person told us) if they had concerns about their well-being or needed to undertake health and safety checks. People's rooms were personalised with items of importance to them. We were told that staff always knocked on bedroom doors and made sure the doors were closed when carrying out personal care. We observed this in practice on several occasions.

Some people could tell us they had been involved in developing their care plans and we saw evidence of this by means of signatures in care records. One person told us, "They [care staff] asked me questions when I moved here. Suppose to get to know me." We did not always see evidence that other people had been involved or their family members. Some relatives we spoke with felt that they had not always been involved with their family member's care. One relative told us, "I was involved in the beginning, but not so much now." The provider was aware that this needed to be improved.

Prior to their admission to the service people were given a service user guide which contained information about the support they could expect to receive. This was available in other formats on request. Information was also available on how to access advocacy services which people had been supported to use. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. We saw records which confirmed that some people had been previously involved with advocacy services. The reception area had lots of documents and leaflets for people and their relatives to read, which explained how to access other services or seek help for particular issues. It also had copies of policy documents which people and relatives could access.

Family and visitors were welcomed into the service and people were encouraged to maintain links with their family and friends. One relative told us, "My first impressions of the home is that I was made to feel welcome and asked if I wanted a drink." Another relative said, "Never had any problems in that respect."

People's care records were stored securely within a locked room and only staff who should have had access to them, did so. This meant the provider maintained confidential records in line with data protection directives.

People were supported to be as independent as possible. This included the provision of specialised equipment, for example plate guards at meal times to help people be able to eat themselves. One person collected their dirty clothes and placed them in laundry bags ready for staff to wash for them. Some people were able to make themselves a cup of tea or similar from a small kitchen area. We observed this being accomplished in a safe manner.

Requires Improvement

Is the service responsive?

Our findings

Care records reviewed were either inaccurate, not in place or not fully detailed to enable staff to view the up to date needs of people. Staff had recently been assigned to work on care records to bring them up to date and this included staff from other nearby services ran by the provider. We found a range of different paperwork in place, which included some from the previous provider. Care plans had started to be much more person centred, and some certainly had some good levels of detail but this was not consistent.

Due to the long service of many staff we saw people's needs being met and this was because staff knew people well.

One person did not have a care plan in place for a particular wound on their body. Although there were other records to show that they had received outside help and support with this as well as care in the home, the details of how this should be cared for was missing. The same person had an oral assessment in place which was not fully completed. The assessment also had conflicting information as to whether they had teeth or not.

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

We saw evidence that staff had responded to the needs of people. One person required to be moved periodically and we saw this occurred and records later confirmed this had been recorded accurately. In their care records were pictures of various bodily positions staff should support them with to make them comfortable and safe. We saw staff moving people appropriately to meet their needs.

One person had the use of a possum to support them to communicate better with staff. A possum is a device which can be used by people to help them communicate with others. Another person had recognisable facial gestures which a family member said staff knew well. Call bells were in place to allow people to request support. One person told us, "There is a call bell there (pointed to it). I can use that if I don't feel well, but have not had to use it." The activity coordinator had the use of a small electronic pad which they said they used to play music.

Activities took place for people who lived at the service. One person told us they enjoyed a number of these and showed us some of the items they had made, including wooden models and some paintings. They said, "Don't like some of the things, but I join in just about everything. We go out as well on a Friday. To places like the coast or the forest. "They also said, "Everyone can go out on trips if they want to. We take turns…its free unless you have to buy tickets to a concert or something like that."

The service had a dedicated activity room which was on the ground floor of the building and had once been a lounge area. During our inspection, this room was moved to the first floor due to the draft coming into the room when people left the building to smoke. We saw a range of equipment for people to use, including paints, craft materials and games. There was a dedicated activity coordinator. They spend their time

working with people in groups and on an individual basis, providing pamper sessions or one to one chats. We observed part of two activity sessions and found some people were not participating and were merely sat around a table with others who were taking part to some extent. Some people we were told, chose not to participate in any activities and preferred their own company.

The provider told us that there was no set budget for activities but that if the activity coordinator wanted to purchase anything, then they just needed to ask. The activity coordinator was not aware of this as they told us all money for activities came from fundraising and gave some examples of this.

The service had a range of people with very complex needs, including those with brain acquired injuries and those people living with dementia. We deemed that more tailored activities needed to be sourced and further training supplied to support staff in providing more specialised activities which were better suited to individuals, for example specialist sensory equipment. We also discussed various computer applications which could be used to further support people at the service, particularly those living with dementia. Including the Liverpool Museum award winning application 'House of Memories'.

We recommend the provider use best practice guidance to tailor activities to each individuals needs.

Complaints procedures (including in easy read format) were on display in various parts of the service, including reception. The provider had a complaints policy in place. We were told that no complaints had been made from the records in place. However, one relative told us they had complained a number of times to the previous registered managers and also made the current manager aware. They said, "I have not made a written complaint, but I have complained many times and [current manager name] is fully aware."

We recommend the provider records all verbal and written concerns or complaints, in line with best practice.

At the time of the inspection, no person was deemed as receiving end of life care. We contacted the palliative nurse teams for care homes and they confirmed they had no current involvement with Elswick Hall Residential Care Home. Some people at the service had do not attempt cardiopulmonary resuscitation (DNARCPR) forms in place. These forms are advance directives for staff to follow in the event of the person's heart suddenly stopping beating. The forms we viewed were appropriate and had been discussed with the person or the family involved. This meant the service was aware of the wishes or best interest decisions made in regard possible end of life decisions made.

Requires Improvement

Is the service well-led?

Our findings

There were issues with record keeping in a number of areas. We found staff had not always completed full dates, times or had not entered the name of the staff member completing a particular form. Kitchen records, pre-assessment records, care plans, risk assessments and mental capacity records were not always up to date with relevant and up to date information or in place.

Audits had not always been completed. During the inspection, the manager told us a medicine audit was underway but could not show us any previous audits having taken place. This meant the provider had previously not been monitoring quality and therefore could not be assured that an effective and safe service was always maintained.

Managers monthly work books were seen for the month of May 2018 which the new manager had completed and sent to the clinical service area manager. These work books provided an overview of the service, for example, information on accidents and incidents, safeguarding concerns, complaints and compliments. We were not able to see previous workbooks as we were told by the clinical service area manager that these were not available as there was an IT issue. They said they would look into this further with their IT team, but were not able to provide any further detail.

We were shown one accident which had occurred recently and there had been no complaints recorded and this information agreed with the workbooks. However, we were not shown any further accidents or incidents or complaints and as we also could not see the managers workbooks, we were unable to confirm if any had occurred or not.

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

There was no registered manager in place. A new manager had taken up the post in the last month. The manager was a registered mental health nurse and had already made some positive changes at the service. The healthcare professionals we spoke with told us the manager was, "Switched on"; "Seems on the ball" and "Has responded well".

Relatives commented, "[Manager] is absolutely lovely. Last manager was very nice but did not get things done. Kept in the background I felt." One member of care staff said, "The manager is much better than what we have had before. He seems to want to get things done and put things right."

Healthcare professionals we spoke with had been impressed by the new manager currently in place. Comments included, "Impressed with the changes they are going to make"; "The new manager is certainly switched on from an infection control point of view"; "They have listened to any concerns and are good with communications" and "We welcome working with them."

The manager and clinical service area manager were available throughout every day of the inspection and

were open and transparent throughout. We also met with the head of health and clinical governance and the quality manager and they showed the same transparency and support to the inspection process.

Action plans produced by the manager and the provider clearly showed a large number of areas which they recognised needed to be addressed, including for example, no registered manager or deputy in place, failures by some of the staff team including lack of interaction, audits not robust and large scale refurbishment work within the service.

The provider had just interviewed and taken on additional 'charge nurses' who would support the manager and provide an oversight of day to day operations on the floor. This was in an aim to address all of the issues they had recently identified.

The manager had reacted to recent concerns raised within the service and undertaken unannounced night checks to ensure that the care received by people during these hours was as it should be. We viewed one record from a 4am check which recorded they had found the visit, "Positive and no concerns raised."

A letter had been sent out to all staff at the end of April to remind them of the standards expected of them, including with regard to personal care, documentation and shift allocation. The letter reminded staff that the provider wanted to deliver the highest standard of care to their residents and have evidence to prove this. Staff said they had received this letter and had been asked to sign in confirmation.

The service is registered for 47 beds, however there were only 45 at the service. The providers website indicated 44 beds but this has since been updated. We raised this with the clinical service area manager and asked that they submit forms to have their registration updated. An application to change this has since been received and the registration has now been updated.

The views of people and relatives were gathered in a number of different methods, including direct contact, suggestion boxes in reception, surveys and meetings. We were given minutes from a number of meetings and it appeared that activities were the only discussion topic. Any other business also included activity related topics, for example bingo and animal shows. One relative we spoke with did not realise relatives meetings took place and another said they had been to them in the past, but felt they were not an opportunity to raise any issues they wanted to. They also went on to say that any issues they had to raise were now just taken straight to the manager.

We recommend the agenda of these meetings be reviewed.

Staff had the opportunity to meet as a team as we viewed minutes of meetings which had taken place. Meetings were now occurring every two months or as the need arose. At the last meeting in April 2018 the new manager introduced themselves and a range of topics was discussed, including shift allocations, people's care and training. There was a comment in the notes regarding care plans and documentation and it was recorded that this was 'a very big job' as all care plans for every person needed to be re-written. The provider had started this, which was positive. However, it had to be noted that the provider had taken over this service in May 2017.

From the healthcare professionals we spoke with, it was clear that the service had not always had a good working relationship with some colleagues outside of the service. This however, was from previous management and the current management team had already made steps to involve a range of health care professionals and seek their advice, including infection control colleagues and tissue viability nurses.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not fully protected from harm. The provider did not have robust medicines management procedures in place. Risk assessments were not always in place. Mattresses were not always set correctly. Foods were not always labelled or dated. Regulation 12 (1) (2) (a)(b)(d)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not acted quickly to address issues since they took over the service in May 2017. Audits and checks were not fully in place or currently being used. Care records were not always up to date or in place. Regulation 17 (1)(2)(a)(b)(c)