Linthorpe Private Nursing Home

Linthorpe Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 8 and 9 January 2018 and was unannounced. This meant the staff and the provider did not know we would be visiting.

Linthorpe Nursing Home is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Linthorpe Nursing Home accommodates up to 28 people in one adapted building across two floors for people with residential and nursing care needs. On the days of our inspection there were 21 people using the service.

The home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not present during our visit however the deputy manager was present and was acting as manager at the time of the inspection.

Linthorpe Nursing Home was last inspected by CQC on 25 May, 6 and 17 June 2016 and was rated Good.

At this inspection, we found the provider did not have the oversight needed to ensure people continued to receive good care. They did not have a robust quality assurance system in place and did not gather information about the quality of their service from a variety of sources. Audits and quality assurance systems did not always identify shortfalls in the requirements of the regulations being met.

Care plans did not reflect a reasonable standard of assessment, planning, implementation and evaluation of care and as a result were not person-centred. People did not have access to meaningful activities in the home or within the local community which reflected their personal preferences and interests. The provider had a complaints policy in place however did not record complaints.

Effective recruitment and selection procedures were not in place and the provider did not carry out relevant checks when they employed staff. Staff used a range of assessment and monitoring tools however these were not always consistently or accurately completed.

Staff mandatory training was not up to date and staff did not receive regular supervisions and an annual appraisal. This meant staff were not support to carry out their roles effectively.

The provider did not have a good understanding of their legal responsibilities with regard to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and staff had not received training in the MCA and DoLS.

There were sufficient numbers of staff on duty in order to meet the needs of people using the service. However we have made a recommendation the provider implements a dependency tool to support staffing levels. Staff demonstrated a good awareness of safeguarding. Medicines were safely administered however the procedures for managing medicines needed to be improved.

People had access to food and drink throughout the day and we saw staff supporting people at meal times when required. People had access to healthcare services and received ongoing healthcare support.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home. Facilities included twelve en-suite bedrooms, several lounges, a dining room, communal bathrooms, shower rooms and toilets and a large communal garden. Entry to the premises was via a locked door and all visitors were required to sign in. The service was clean and tidy.

People who used the service and their relatives were complimentary about the standard of care at Linthorpe Nursing Home. We saw staff supporting and helping to maintain people's independence. People were encouraged to care for themselves where possible. Staff treated people with dignity and respect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During our inspection we found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

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.

People, staff and visitors were not safe because staff failed to recognise and monitor risks. Risk assessments and care plans did not reflect current risks.

Effective systems were not in place when accidents and incidents took place. Effective recruitment checks were not carried out.

Freestanding wardrobes were not secure. Chair scales had not been calibrated and there were no planned checks in place for falls sensor mats.

The procedures for managing medicines needed to be improved.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not properly supported to provide care to people who used the service through a range of mandatory and specialised training, supervision and appraisal.

People had access to food and drink throughout the day and we saw staff supporting people when required.

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

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst we observed staff to be caring throughout the inspection, it was evident from the issues we found the provider was not ensuring the service was caring overall.

People we spoke with expressed satisfaction with the service and they felt well cared for.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

Staff interacted with people in a caring manner and supported people to maintain their independence.

Is the service responsive?

Requires Improvement 

The service was not always responsive.

Care plans did not reflect a reasonable standard of assessment, planning, implementation and evaluation of care and as a result were not person-centred.

People did not have access to a range of activities in the home or within the local community.

The provider had a complaints policy in place however did not record complaints. People told us they knew how to make a complaint.

Is the service well-led?

Inadequate 

The service was not well-led.

The home had a registered manager in place. Staff we spoke with told us they felt unable to approach the registered manager and report concerns.

The provider did not have a robust quality assurance system in place and did not gather information about the quality of their service from a variety of sources.

An ineffective auditing system was in place.

The provider had policies and procedures in place that did not take into account guidance and best practice from expert and professional bodies.

Ineffective procedures were in place to record complaints.

The service had limited links with the local community.

Linthorpe Nursing 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 8 and 9 January 2018 and was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two adult social care inspectors, two specialist advisers in nursing and an expert by experience. The expert by experience had personal experience of caring for someone who used this type of care service.

Before we visited the home we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints.

We contacted professionals involved in caring for people who used the service, including commissioners, safeguarding, infection control and medicines management. Information provided by these professionals was used to inform the inspection.

During our inspection we spoke with nine people who used the service, three relatives and a friend of a person who used the service. We spoke with the acting manager, two nurses, seven care staff, the administrator, laundry assistant, cook and maintenance worker.

We looked at the personal care or treatment records of twenty one people who used the service and observed how people were being cared for. We also looked at the personnel files for five members of staff.

We reviewed staff training and recruitment records. We also looked at records relating to the management of the service such as quality audits, surveys, policies and policies.

Inadequate

Is the service safe?

Our findings

Effective procedures were not in place to ensure the safety of people, staff and visitors at all times. The practices in place by staff meant that people were placed at continued risk of potential harm. This is because staff failed to highlight and monitor risk and did not ensure accurate and up to date care plans and risk assessments were in place when incidents occurred.

An incident record, dated 11 December 2017 stated that a person had been shaking a wardrobe and pulled the wardrobe over on themselves with no apparent injuries. No checks had been put in place following the incident and the person's care plan and risk assessment had not been updated. This meant that people had not been protected from risks of their environment.

The provider's accident management and recording policy and procedures provided staff with guidance on the reporting of injuries, diseases and dangerous occurrences however it did not detail the incident notification requirements of CQC. For example, we found a record of an accident dated 9 December 2017 which described how a person had slipped and fell in their bedroom with a laceration to their head. CQC had not been notified of this incident. The acting manager and the administrator told us they were not aware of the notification requirements of CQC. Accidents and incidents were recorded however there was no evidence the registered manager reviewed the information monthly in order to establish if there were any trends and made referrals to professionals when required, for example, to the falls team.

People had risk assessments in place relating to, for example, falls, pressure damage and moving and handling however assessments were not always consistently or accurately completed. For example, there were two risk assessments in place for a person at risk of developing a pressure ulcer dated 19 December which were contradictory. The "Douglas" assessment scored 19 (Douglas score of 18 or below indicates risk). The "Waterlow" score indicated 17 (Waterlow score of 15-20 indicates high risk).

We saw staff used a range of assessment and monitoring tools however these were not always consistently or accurately completed. For example, one person had a care plan in place to reduce the risk of pressure damage. The care plan did not detail the frequency of turns to alter body position and the turn chart had not been completed for 10 hours. This did not provide assurance of regular turning to reduce risk of pressure damage.

Some people chose to smoke in their bedrooms and use electrical extension leads for a variety of electrical appliances however there was no evidence of appropriate risk assessments in place. This showed that people living at the home were not protected from risks from their environment and arrangements to reduce these risks had not been taken. We explained these concerns to the acting manager and issued an Initial Inspection Feedback Summary to bring this to the attention of the registered provider and registered manager. The acting manager told us this would be addressed immediately. We also contacted Cleveland Fire Brigade and advised of our findings.

The staff team were stable and a number of staff had worked at the home for over ten years. We found staff

records were not consistent in presentation, poorly organised and some lacked required information such as references, photographs and proof of identity. We saw a Disclosure and Barring Service (DBS) check had not been undertaken before a member of staff had begun working at the home. For example, the member of staff had commenced their employment on 2 September 2017 and their DBS was dated 2 October 2017.

The provider did not have robust procedures in place to routinely check the suitability of staff working at the home. For example, staff records showed that most recent dates for staff DBS checks were 2007. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults.

The provider was not following the latest guidance in medicines management. The provider's medicines management policy dated May 2016 did not refer to guidance from the National Institute for Health and Care Excellence (NICE) and did not cover all key areas of safe and effective medicines management. The copy of the British National Formulary available for staff reference, which is a pharmaceutical reference book produced by the British Medical Association and the Royal Pharmaceutical Society of Great Britain, was dated 2010. The home did not have a treatment room and topical medicines were not always stored appropriately.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

We could not be assured, from the records available to us, that the nursing staff held a valid professional registration with the Nursing and Midwifery Council (NMC). For example, there were no registration numbers recorded for three nurses and one nurse's registration had expired in July 2017. The NMC is the regulator for all nurses and midwives in the United Kingdom. When a nurse is registered with the NMC, they have a pin number. Without a pin number a person cannot work as a nurse or a midwife in the United Kingdom. We asked the acting manager to obtain evidence that nurses had up to date registration with the NMC.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and proper persons employed.

Equipment was in place to meet people's needs including hoists, pressure mattresses, shower chairs, wheelchairs and pressure cushions. Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). However we found weight scales had not been calibrated. This meant we could not be sure they remained safe to use. There were no planned checks in place for sensor mats. This meant we did not know if they remained effective.

People had freestanding wardrobes in their bedrooms which had not been safely secured to the wall to prevent injury. We asked the acting manager to take immediate action to address this and bring it to the attention of the provider and registered manager.

This was a breach of Regulation 15 [Premises and Equipment] of The Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

We discussed staffing levels with the acting manager and looked at staff rotas. The acting manager told us that the levels of staff provided were based on the dependency needs of people who used the service. However they were unable to provide a dependency tool to support this at inspection. There were nine

members of care staff on a day shift which comprised of two nurses and seven care staff. There was one nurse and three to four care staff on duty at night. The acting manager told us that any staff absences were covered by existing home staff or regular agency staff.

The staff, people who used the service, relatives and visitors did not raise any concerns about staffing levels within the home. One person told us "There is always someone to help me and nothing is too much trouble." We observed sufficient numbers of staff on duty and call bells were responded to by staff in a timely manner. We recommend the provider implements a dependency tool to support staffing levels.

People who used the service, their relatives and friends told us they felt safe at Linthorpe Nursing Home. One person told us, "It is a lovely place to be I am so happy to be here" and another person said, "Compared to where I was, before I never really felt supported there and safe, so this is wonderful." A relative told us, "I have no concerns about my relative in the home as they are safe and well looked after." A friend who had not seen a person who used the service for many months was pleased at to how well they looked and said that the person's improvement was because, "They were safe and supported."

The provider's safeguarding adult's policy provided staff with guidance regarding how to report any allegations of abuse, protect vulnerable adults from abuse and how to address incidents of abuse. The staff we spoke with demonstrated a good awareness of safeguarding and whistleblowing. They knew the different types of abuse and how to report concerns.

Medicines were supplied by a local pharmacy chain. Staff were able to explain how the system worked and were knowledgeable about people's medicines. We looked at the medicines administration charts (MAR) for people and found there were no omissions. The MARS folders did not contain up to date staff signature samples. Photo identification for each person was in place and allergies were recorded. Medicine administration was observed to be appropriate. We looked at the controlled drugs records (CD) for four people. Appropriate arrangements were in place for the management, administration and disposal of controlled drugs (CD), which are medicines which may be at risk of misuse. We saw temperature checks for the refrigerator were recorded on a daily basis and all were within recommended levels. Staff who administered medicines were trained. We saw that medicine audits were up to date and included action plans for any identified issues.

Hot water temperature checks had been carried out and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) Guidance Health and Safety in Care Homes 2014. We looked at the records for portable appliance testing, gas safety and electrical installation. All of these were up to date. This meant the provider had arrangements in place for managing the maintenance of the premises.

We saw that entry to Linthorpe Nursing Home was via a locked door and all visitors were required to sign in. A fire emergency plan was displayed in the reception area. This included a plan of the building. A fire risk assessment was in place and regular fire drills were undertaken. The checks or tests for firefighting equipment, fire alarms, nurse call system and emergency lighting were all up to date. The home had premises risk assessments in place, which contained information on particular hazards and how to manage risks including slipping and tripping, using the lift and moving and handling.

We looked at a copy of the provider's business continuity plan dated April 2017. This provided the procedures to be followed in the event of a range of emergencies and emergency contact details. People had personal emergency evacuation plans (PEEPS) in place which described the emergency evacuation procedures for each person who used the service.

The home was clean and maintained. The en-suite bathrooms, communal bathrooms, shower rooms and toilets were clean, suitable for the people who used the service and contained appropriate, wall mounted soap and towel dispensers. The acting manager told us the home had three infection control champions, however we found that most staff training in infection, prevention and control was not up to date. This meant people may not be protected from the risk of acquired infections. We saw infection control audits and cleaning schedules were up to date. Gloves and aprons were readily available to staff and were used as necessary. A person told us, "The home is clean and tidy and so is my room there is a lovely homely atmosphere here. The domestics are always on the go and this place takes a lot of cleaning as it is old."

Requires Improvement

Is the service effective?

Our findings

Staff did not receive support to carry out their roles safely. We identified training and appraisals were not up to date. As a result we found staff knowledge in areas such as the Mental Capacity Act 2005 (MCA) was limited.

Staff training records showed that training was not up to date. We could see some planned dates were in place for training in infection control, fire safety, safeguarding and MCA. Specialised training in speech and language, use of a syringe driver and wound care had been carried out.

Staff were not supported through their induction programme and had not carried out mandatory training. Mandatory training is training that the provider thinks is necessary to support people safely. Staff had not enrolled on to the care certificate and had not participated in regular reviews to monitor their progress and determine whether any additional support was needed. The care certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

Staff did not receive regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Records showed that staff had not received an annual appraisal in 2017 and although supervisions were recorded every two months, supervision notes were brief, three or four lines and were not signed by staff. Staff questioned the effectiveness of their supervisions and appraisals. For example, one member of staff had no recollection of having an annual appraisal and told us, "I know what supervision is but I've never had one here." Another staff member told us they had not had a supervision and said, "We were given a sheet of paper already written on to sign for an appraisal."

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the acting manager did not have a good understanding of their legal responsibilities with regard to the MCA and DoLS and staff had not received training in the MCA. Applications for DoLS had been submitted to the supervisory body and were authorised for six people however CQC had not been notified. The staff we spoke with were not aware of the requirements of DoLS, the Mental Capacity Act and the Best Interest decision making process. This was

reflected in care records. We found the provider was not following the requirements in the DoLS.

Some people had mental capacity assessments in place however consent to care and treatment was not consistently documented in people's care plan documents. There was limited evidence that people and their relatives were aware of and involved in the care planning and review process. There was no evidence that best interest decisions had been carried out to look at the least restrictive options for people.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent.

People had access to a choice of food and drink throughout the day and we saw staff supporting people in the dining rooms at meal times when required. People were supported to eat in their own bedrooms if they preferred. We saw menus displayed in the dining room which detailed the meals available throughout the day. Meal times were relaxed and unhurried. We observed staff chatting with people and giving them a choice of food and drink. One person told us, "Staff look after me well they know to look for signs and symptoms and if I am not wanting to eat they try and get me something light and tasty, just for me." Another person said, "I really like the food here, it is uncomplicated and it is food I know." A third person said, "I sometimes ask for a sandwich and cook is great she always will have something I like." A fourth person told us, "The food is good, tasty and well cooked."

We spoke with the cook who told us about people's special dietary needs and preferences. The home had been awarded a "5 Very Good" Food Hygiene Rating by the Food Standards Agency on 20 December 2017. The provider had nutrition and hydration policy in place and most staff had completed training in food safety. The acting manager told us the home had three nutrition champions however we found that staff training in nutrition was not up to date. The care records we looked at demonstrated people's weight and nutrition was monitored however we could not be assured that people weights were accurate as weight scales had not been calibrated. A relative told us, "[Name] has gained weight whilst in here and that's only a few months. I am going to ask the staff to keep an eye on that because it might affect their walking. It must be contentment and good cooking."

People had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including GP's, district nurses, tissue viability nurses and dieticians. One person told us, "I think the staff know there is something not quite right with me before I do. They are very good." A relative said, "We get calls when [Name] is unwell and even if we are on holiday we know they are in safe hands. The nurse comes in daily and they would alert the GP if needed." This meant the service ensured people's wider healthcare needs were being met through partnership working.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home and corridors were clear from obstructions. The home was not suitably designed for people with dementia type conditions. The acting manager told us about the programme of improvements planned for the service including decorating the lounge and dining room, changing the upstairs bathroom into a shower room and replacing the kitchen flooring.

Requires Improvement

Is the service caring?

Our findings

People who used the service and their relatives were complimentary about the standard of care at Linthorpe Nursing Home. One person told us, "From the way they [staff] help me in the shower to how they support me whilst walking or eating or just by being there with me; I would say they [staff] are all wonderful and I will not hear a bad word said against them." Another person said, "I'm happy here." A relative told us, "My relative now enjoys a better quality of life and this is due to the staff and positive attitude of the care home."

People we saw were well presented and looked comfortable. Staff knew people's names and spoke with people in a kind and caring manner. Staff interacted with people at every opportunity and were polite and respectful. We heard staff asking people, "Are you going shopping soon with [Name] for new shoes in the sales?" "Did you get that jumper you wanted?" And "When is the new baby due?" We saw staff knocking before entering people's rooms and closing bedroom doors before delivering personal care. One person told us, "It is not nice having to depend on others for personal care but they [staff] do it so professionally it takes away the embarrassment."

We saw staff assisting people, in wheelchairs and specialist chairs, to access the lounges, bedrooms and dining room. Staff assisted people in a calm and gentle manner, ensuring the people were safe and comfortable, often providing reassurance to them. We heard a member of staff ask a person if they would like their door closing and another about where they would like their lunch. A relative told us, "[Name] for medical reasons has to get up early and have breakfast, but afterwards they can pop back to bed for a rest and the staff keep an eye on them." This meant that staff treated people with dignity and respect.

We saw people were assisted by staff in a patient and friendly way. We saw and heard how people had a good rapport with staff. Staff knew how to support people and understood people's individual needs. For example, we observed staff popping into rooms where people were in bed or just wanted their personal space, to check they were alright. One person told us, "The staff take trouble to find out what I like and dislike." A member of staff told us about a person who had very limited communication but how staff knew from their facial expressions what they were attempting to communicate. This meant that staff were working closely with individuals to find out what they actually wanted.

We saw the bedrooms were individualised, some with people's own furniture and personal possessions. We saw many photographs of relatives and special occasions in people's bedrooms. A person told us, "I can have my own furniture and bits and pieces, so it is like home." All the people we spoke with told us they could have visitors whenever they wished. The relatives we spoke with told us they could visit at any time and were always made welcome.

A member of staff was available at all times throughout the day in most areas of the home. We observed people who used the service receive help from staff without delay. A person told us,
"The staff come and sit and talk to me for a rest and I love to see them." We saw staff interacting with people in a caring manner and supporting people to maintain their independence. A person told us, "I can choose my food, clothes, whether or not I have a shower or bath and if I want to stay in bed all day that's fine as

well." A member of staff told us how they encouraged a person to wash their own hands and face and pick out their preferred clothes.

At the time of our inspection no person in the home had an advocate. Staff understood the purpose of people having advocates and gave us an example of someone who had previously been allocated an advocate to support them in their decision making. An advocate is a person who helps another person make decisions and represents their views to others. Staff were able to tell us about people's relatives and how they were involved in their care. We saw family members had been contacted and kept informed about their relative, for example when they needed a GP. Advocacy information was made available to people who used the service.

We saw people were provided with information about the service in the registered providers 'statement of purpose' and 'service user guide' which contained information about the staff team, services, meals, spiritual, advocacy and complaints. Information about health and local services was also prominently displayed on notice boards throughout the home.

Whilst we observed staff to be caring throughout the inspection, it was evident from the issues we found the provider was not ensuring the service was caring overall.

Requires Improvement

Is the service responsive?

Our findings

We identified that the service was not responsive to people's individual needs. This meant people did not always receive care and support which was in line with their needs, wishes and preferences. We found that people's care plans were not reflective of their individual needs. For example care files were not consistently presented. They were disjointed, poorly organised and difficult to follow. Clinically relevant, hand written, informal notes were left loose in care plan files. Overall, we found that care plans did not reflect a reasonable standard of assessment, planning, implementation and evaluation of care and as a result were not person-centred.

People's dependency needs were assessed and recorded on a dependency rating scale contained within their individual care plan files however there was no documented explanation of what the overall score represented or how this correlated to the determination of staffing levels.

Percutaneous endoscopic gastronomy (PEG) feeding is a means of providing nutrition and hydration to people through a feeding tube inserted into the stomach. For people who needed this support, care plans were in place to provide staff with information about how to provide support people needed. However we found that the care plans for this support had not been updated since 2014. This meant we could not be sure people were receiving the support which they needed.

Care plans were not always detailed enough to ensure people received safe and appropriate care. For example, one person's insulin dependent diabetes care plan did not highlight how the goal of maintaining a healthy blood sugar level was to be met, how it was being monitored, what the warning signs were if their blood sugar level became abnormal and what action to take it there were concerns.

Evaluations were very repetitive, lacked focus and were not always up to date. For example, one person's care plan for PEG feeding had been developed in March 2017 however there was no evidence of evaluations in the past 10 months. Another person's care plan for pressure damage was developed in September 2016 and had not been reviewed until December 2018. There was no evidence of care plan audits being carried out and staff had not received training in care planning.

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

People did not have access to meaningful activities which reflected their personal preferences and interests. There was no evidence to show that people were involved in planning activities and no feedback had been sought. Staff had not considered people's preferences to plan meaningful activities or considered people's specialist needs, for example, people living with dementia or people with limited mobility. There was no evidence to show that staff had provided people with information about local events or activities taking place in the local community.

People told us they felt sad that they didn't do anything interesting. One person told us, "There isn't much

happening. We were making Christmas decorations but a few weeks before Christmas we were just told that we wouldn't be finishing them. A lot of us had really enjoyed doing something." Another person said, "It is hard in here because some of us can still do things but a lot of the people here just sit and watch television or sleep and I am not quite ready for that."

The staff member previously responsible for arranging activities told us, "The registered manager stopped all activities in December 2017 with the exception of Mr Motivator every other week." They said, "The registered manager decided that people were not really interested in activities so the decorations and Christmas activities just stopped." They told us, "Some staff will do a bingo session in the morning and sometimes there is music or a film but there is very little of interest overall." The acting manager told us how someone from the local infant school had contacted them to ask if someone would like to join them on a regular basis and interact with the children. One person who used the service volunteered, and subject to their DBS check, would be joining the group at the school.

We saw Do Not Attempt CP Resuscitation (DNACPR) forms were included in care records and we saw evidence that the person, care staff, relatives and healthcare professionals had been involved in the decision making.

Some people spent their time in bed and we saw staff call in and spoke to them regularly to reduce the potential of social isolation. People were encouraged and supported to maintain their relationships with their friends and relatives. A person told us, "When my family visit they are made welcome and get a cuppa and biscuit." There were no restrictions on visiting times.

We saw a comments/complaints box in the entrance hall and a copy of the provider's complaints and concerns policy on display. The policy informed people who to talk to if they had a complaint, how complaints would be responded to and who to contact, if the complainant was unhappy with the outcome, for example the local authority. People and their relatives told us they knew who they could go to with any concern or complaint and all felt that they would be listened to and that the concern would be addressed.

One person told us, "If I had a complaint I would talk to the senior or tell my daughter" and another person said, "I would try hard not to complain, it is much nicer to just have a chat." Another person told us, "I did complain a number of months ago because my friend's food was left in front of them, they have a visual impairment so couldn't see the food. I was really upset for my friend and the senior said they would deal with the problem at once and they did." We also found a complaint in a relative's quality assurance questionnaire referred to the smell from the sluice room which was "much improved". However the provider did not keep a record of complaints.

Inadequate

Is the service well-led?

Our findings

The provider had not notified the CQC of all significant events, changes or incidents which had occurred at the home in line with their legal responsibilities and statutory notifications were not submitted in a timely manner. For example, the absence of the registered manager, DoLS authorisations and the loss of heating to part of the home for 3 days in December 2017.

This was a breach of Regulation 14: Absence of a registered individual, Regulation 18 (2): Application to deprive a person of their liberty and Regulation 18 (2)(g): Events that stop the service running safely and properly of the Care Quality Commission [Registration] Regulations 2009.

We will take action outside of this inspection to address this. We will report on any actions once they have been completed.

The home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. The manager had been registered with CQC since 4 January 2016. The registered manager was not present during our visit however the deputy manager was present and was acting as manager at the time of the inspection.

Staff told us that the registered manager was not supportive of them and as a result they felt unable to approach the registered manager or to report concerns. When staff did approach the registered manager, they did not find the interaction productive. A staff member said the registered manager "Can be a bit harsh." Another member of staff told us, "A lot of people are afraid of her." A third member of staff told us, and another said, "[Registered manager is] is destroying a good nursing home."

Some staff told us the registered manager was unprofessional. One staff member told us the registered manager, "Has screamed in my face a couple of times." Another staff member described the registered manager as, "Very unprofessional." A third member of staff told us, "If [Registered manager] comes back I'm leaving."

An ineffective auditing system was in place. This meant the provider and the registered manager did not have adequate oversight of the service. The quality assurance procedures in place did not cover all aspects of the service, for example, care plans and accidents and as a result they were not identifying areas of concern. Where audits were in place, for example, health and safety, fire and falls, they had not been carried out robustly to identify where improvements were needed. This meant that the service had deteriorated significantly since the last inspection.

The provider had policies and procedures in place that did not take into account guidance and best practice from expert and professional bodies. For example, the provider's nutrition and hydration policy dated January 2017 made no reference to guidance from the National Institute for Health and Care Excellence (NICE) and the health and safety policy date February 2017 made no reference to guidance from the Health and Safety Executive. Policies were reviewed regularly however some referred to another of the provider's

care homes, no longer registered with CQC, instead of Linthorpe Nursing Home. The acting manager told us they could not evidence that staff had read and understood the policies or were applying their principles in practice.

Ineffective procedures were in place to record complaints. Although we could see that complaints made had been dealt with, the systems in place did not reflect this. This meant that the provider and registered manager could not monitor complaints to look for patterns and trends in order for action to be taken in line with service improvement.

The provider did not seek regular feedback (meetings and surveys) from people and relatives to ensure people received good care and did not have systems in place to promote continuous improvement.

The provider did not hold regular residents and relatives meetings. The provider did not carry out regular customer satisfaction surveys. The cook told us, "There have been no user surveys of food over the last couple of years." We did see three completed relatives quality assurance questionnaires dated December 2017. People responded positively about the food, accommodation, level of care and communication. However one relative commented about the lack of interactive games and outings for people which had not been acted upon.

A staff meeting held in July 2017 had been well attended by staff. Minutes were in place and discussion items included holidays, housekeeping, rotas and resident's choices. We saw another staff meeting had been held in December 2017 to discuss the possible closure of the service and the behaviour of the staff and the registered manager. The minutes stated that the meeting was not well attended. Staff told us the registered manager did not always listen to them and their ideas, and the recommendations they made to improve the quality of care were not always considered.

This was a breach of Regulation 17 [Good Governance] of The Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

The acting manager told us the home had an open door policy, meaning people who used the service, their relatives and other visitors were able to chat and discuss concerns at any time. Staff were complimentary about the acting manager and the 'We can do this' approach to everything which was motivating for the staff. One staff member told us the acting manager, "Has brought some morale back, staff are happy at the present time." Another said, "Communication is 100% better now." A relative told us, "The new manager has always got time to have a chat and reassure which really is all that is needed sometimes."

The service had limited links with the local community one person who used the service had volunteered to join a group at the local infant school.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to meet the requirements of the Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to: a) assess risks to people's health and safety when receiving care or treatment, b) do all that was reasonably practicable to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure equipment was properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Records used in the service were incomplete or inaccurate. The provider failed to have effective systems in place to monitor the quality of the service.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to carry out checks on staff to ensure they were of good character.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support.