Embrace (UK) Limited

St Cuthberts

Inspection report

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Ratings

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

Overall summary

The inspection took place on 3 and 7 November 2014 and was unannounced. St Cuthberts was last inspected in June 2014 and was found to be breaching three regulations. In particular, we found medicines records were incomplete and people did not receive the consistent and uninterrupted support they needed to meet their nutritional needs. There was also a lack of social interaction or an activity programme and audits had not been successful in identifying shortfalls in the quality of people's care records. We found the provider had made progress with the action they had committed to undertake and were no longer in breach of these regulations.

St Cuthberts is registered to provide nursing or personal care for up to 39 people. At the time of our inspection there were 20 people living at St Cuthberts, some of

Summary of findings

whom were living with dementia. The home did not have a registered manager. A new manager had been appointed and had been in post three weeks at the time of our inspection.

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.

During this inspection we found the provider had breached Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because staff were not receiving regular one to one supervision from their line manager. You can see what action we told the provider to take at the back of the full version of the report.

The provider had systems to ensure new staff were suitable to work with vulnerable adults. Staff told us they felt supported and had recently had an appraisal. We viewed training records which confirmed that staff had completed training to help them fulfil their caring role.

We viewed medicines administration records for people who used the service. The quality of medicines records had improved. We found these had been completed accurately to confirm whether people had been given their prescribed medicines. We observed during a medicines round that medicines administration was not always carried out in line with best practice.

People who used the service and family members told us the home was a safe place to live. One person said, "Staff are nice to me."

Staff had a good understanding of safeguarding and whistle blowing and knew how to report any concerns they had. Staff told us they felt the management team would take any concerns seriously and would deal with them appropriately.

There was usually enough staff to meet people's needs and to maintain their safety. However, on the second day of our inspection we found the home was operating with one less staff on the dementia floor.

We found the home was clean and tidy. However, we observed the home was in need of refurbishment. Staff described the environment as "lacking stimulation" and "bland." The clinical lead told us a refurbishment plan was being developed, including redecorating the upstairs lounge.

During our observations over lunch time we found staff were present in the dining room for most of the time to ensure people were supervised to keep them safe. We found people who required one to one assistance received this uninterrupted and at a pace that was appropriate to their needs. We found people still had to wait to receive their lunch, however not as long as when we observed lunch time during our previous inspection. During our observation we found one person did not receive prompts and encouragement to eat their lunch. We saw from viewing people's records that where they had been assessed as at risk of poor nutrition, action was taken to support them to meet their nutritional needs.

People were asked to give their permission before they received any care. Staff told us that if a person refused they would respect their decision. One staff member said, "We cannot force a person."

Staff told us they knew how to support and manage people's behaviours that challenged the service. However, we observed this was not always carried out in line with people's agreed care plans. People had access to a range of health professionals when required. This included speech and language therapists, the falls team, the challenging behaviour team and specialist nurses.

Family members told us their relatives received good care. One family member said, "Care in this home is excellent". They told us about how [their relative] was treated "with dignity and respect." They also said, "Care was exceptional. [My relative] was always clean, tidy and well-presented and their hair and nails always clean." Another relative said, "I find the staff very caring people and supportive. [My relative] is always well-presented, clean and tidy, and the staff keep me updated on how she has been."

We observed people received one to one interaction from staff to varying degrees. Staff interaction was done in a friendly and professional manner. Staff were kind, caring and considerate towards people. During our inspection we observed two occasions where staff did not respond to people's needs in a timely manner.

Summary of findings

Staff described how they treated people with dignity and respect. We observed staff talking to people and found they were respectful and polite. Staff also described to us how they promoted people's independence and supported them to make choices. These included what clothes they wanted to wear, food choices and whether they wanted to go out or stay in.

People had their needs assessed and care plans had recently been updated to reflect people's current needs. Care plans we viewed were person centred and contained details of people's preferences including their likes and dislikes. We found the clinical lead (deputy manager) and qualified nurses evaluated care plans monthly. However, we found the quality of the evaluation record required improvement by providing more meaningful information about each person. People had the opportunity to take part in activities, such as playing games, painting, watching a film or receiving one to one time with staff. One staff member said, "We try and do as much as we can." Staff told us one to one time usually included hand massages, manicures and chatting.

The manager and clinical lead were both new to the service and were still settling into their role. Staff told us the manager and clinical lead were supportive and approachable. We found the provider had specific values that it expected staff to work towards. We found these were not embedded into care delivery at St Cuthberts.

The provider had a system of checks and audits as part of its quality assurance programme to assess the quality of care provided. We found that because of a number of changes to the management team over recent months, these had not been effective in driving forward improvements.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The quality of medicines records had improved since our last inspection. We observed during a medicines round that medicines administration was not carried out in line with best practice. People and family members said they felt safe living at St Cuthberts.

The provider had recruitment systems in place to ensure new staff were suitable to work with vulnerable adults. There was usually enough staff to meet people's needs and to maintain their safety. Staff had a good understanding of safeguarding and whistle blowing and knew how to report any concerns they had.

We found the home was clean and tidy but in need of refurbishment. Staff also told us they felt the environment needed to be improved. The provider told us a refurbishment plan was being developed.

Is the service effective?

Requires Improvement

The service was not always effective. Most people received the support they needed to meet their nutritional needs. Where people required one to one support with eating and drinking they received this uninterrupted. Drinks and snacks were available throughout the day.

The manager was aware of the Deprivation of Liberty Safeguards (DoLS) and was making applications for DoLS in line with the Mental Capacity Act 2005 (MCA). Staff we spoke with did not demonstrate a sound knowledge of the MCA.

Staff were not receiving regular supervision from their line manager. A plan had been developed for staff to receive regular supervision from their manager. Staff had completed the training they needed to fulfil their caring role.

Is the service caring?

Requires Improvement

Most aspects of the service were caring. We found staff were kind, caring and considerate towards the people in their care. However, we observed staff did not always respond quickly to support people who required assistance.

Family members told us their relatives received good care. Their comments included, "Care in this home is excellent", "Care was exceptional. [My relative] was always clean, tidy and well-presented and their hair and nails always clean", and, "I find the staff very caring people and supportive. [My relative] is always well-presented, clean and tidy, and the staff keep me updated on how she has been."

Summary of findings

Staff had a good understanding of the importance of maintaining people's dignity and respect, and promoting their independence. One family member we spoke with said staff treated their relative "with dignity and respect."

Is the service responsive?

Requires Improvement

The service was not always responsive. Care records showed that planned activities took place, such as bingo sessions, watching films, organising entertainers to visit the home and taking people on outings.

People had their needs assessed when they moved into St Cuthberts and this information was used to develop person centred care plans. Although care plans were reviewed regularly, we found review records were not meaningful.

Further opportunities for people who used the service and family members were being developed, such as face to face meetings.

Is the service well-led?

Requires Improvement

The service was not always well led. The home did not have a registered manager. A new manager had been appointed and had recently started working at the service. Staff told us the new manager and deputy were supportive and approachable.

Staff told us and records confirmed, that regular staff meetings were now being held and used to encourage feedback and suggestion from the staff team.

The provider had a system of checks and audits as part of its quality assurance programme to assess the quality of care provided. However, these had not been successful in driving forward sustained improvements to the service as there had not recently been a settled management team in post.

St Cuthberts

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 3 and 7 November 2014 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist adviser and an expert-by-experience both with experience of dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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. We reviewed the information included in the PIR along with other information we held about the home, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also spoke with the local authority commissioners for the service.

We spoke with four people who used the service and five family members. We also spoke with the new manager and deputy, one senior care assistant and three care assistants. We observed how staff interacted with people and looked at a range of care records. These included care records for five of the 20 people who used the service, 20 people's medicines records and recruitment records for five staff.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

Requires Improvement

Is the service safe?

Our findings

When we inspected this service in June 2014, we were concerned that medicines administration records (MARs) were inaccurate and incomplete. In particular, we found gaps in the MARs for 12 people, where staff had not signed to confirm medicines had been given. We asked the provider to send us an action plan to tell us how they would make improvements and become compliant with the regulations. The provider gave assurances in their action plan they would meet the requirements of the regulations by 3 October 2014.

During this inspection we found the provider had made progress with the actions they had committed to undertake. We viewed 20 people's MARs for the period 6 October 2014 to 2 November 2014 and found the quality of the recording had improved. For example, the medicines records we viewed had all been completed fully to confirm people's medicines had been given. Where medicines hadn't been given a code had been added to the MAR to confirm the reason for this. We viewed records which showed trained and competent staff were responsible for administering medicines.

We observed the morning medicines round for people living on the first floor. This was mostly people living with dementia. We observed medicines had been pre-potted with name labels ready for administering to people. Whilst observing the medicine round we saw that MARs were not signed promptly when the medicines were given to people but rather at the end of the medicines round. The clinical lead (deputy manager) recognised and accepted this was incorrect and unsafe practice. However, they said it was not their usual practice and only done on the day of the inspection because they needed to "save time" to attend a care review meeting. We discussed our observations with the regional manager and manager who confirmed this would not happen again.

We found people's care records did not include a medicines management plan. However, we found most people had 'as required' medication protocols in place to guide staff about when and how to administer these medicines. People's medicines had not recently been reviewed by their GP. The clinical lead, who was new in post, told us this was a priority for the service as they considered prescribing was not always in line with current practice for people living with dementia. This meant the provider had been pro-active in identifying action was needed to ensure people received the most appropriate medicines to meet their needs.

People who used the service told us the home was a safe place to live. One person said, "Staff are nice to me." Another person said, "I am happy in the home, staff are nice, treat me well but I would shout if they did not." Family members also told us they felt their relative was safe. We found the provider assessed people, using recognised tools against a range of potential risks. This included the risk of poor nutrition and skin damage.

Staff we spoke with had a good understanding of safeguarding adults and how to report any concerns they had. Staff gave us examples of various types of abuse and potential warning signs. For example, unexplained marks, flinching, aggression, shouting out and looking scared. Staff said that if they had any concerns they would speak with the manager or clinical lead. We viewed the safeguarding log which showed there had been five safeguarding incidents. These had all been logged and dealt with through the local authority's safeguarding procedures. Staff were also aware of the provider's whistle blowing procedure and said they would report any concerns they had. They told us they felt management would take concerns seriously and they would be dealt with. One staff member said, "You have to report it if you see things going on."

Staff told us they felt there were usually enough staff to meet people's needs. Some staff told us there didn't used to be enough staff but things had improved as staffing levels had gone up. One staff member said staffing levels were, "Okay now, it wasn't when I first started." They also said that staff used to, "Run around like a headless chicken." Another staff member said, "Staffing levels were really bad before. We have an extra member of staff now. We spend more time with residents, we can have a chat with them." Another staff member said about staffing levels, "We're fine at the moment. We spend more time with people, have a laugh with them." We observed throughout the day that staff were present around the home.

On the second day of our inspection we saw staff levels had reduced on the dementia floor to the levels where we had previously identified concerns. For example, staffing levels had reduced to one qualified nurse and two care staff

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Is the service safe?

instead of the usual three care staff. Although staff told us this was unusual, when we checked the rotas for the week of our inspection there had been other occasions when staffing had been reduced. Staff told us they had been unable to find cover for the shortages. We discussed this with the manager and regional manager who told us they could meet people's needs with two staff because there were fewer people now and the dependency levels of the remaining people were less. However, we found no evidence an assessment had been undertaken prior to operating with reduced staffing levels which would have considered the impact on people who used the service.

There were systems in place to ensure new staff were suitable to care for and support vulnerable adults. We viewed the staff records for five recently recruited staff. We found the provider had requested and received references in respect of prospective new staff, including one from their most recent employment. A disclosure and barring service (DBS) check, previously known as criminal records bureau (CRB) checks, had been carried out before confirming any staff appointments. These checks were carried out to ensure people did not have any criminal convictions that may prevent them from working with vulnerable people.

The home was clean and tidy with no unpleasant odours. We saw domestic staff continually cleaned throughout the day of our inspection. For example, we saw staff cleaning the dining area, sweeping and mopping the floors. However, the internal decoration required updating to provide a more stimulating environment for people, particularly those living with dementia. The fixtures and furnishings looked old and some of the décor, including the reminiscence decorations were in need of refurbishment. All of the staff we spoke with commented the décor in the home was outdated and needed to be improved for people. Staff described the environment as "lacking stimulation" and "bland." The clinical lead told us a refurbishment plan was being developed including redecorating the upstairs lounge.

The provider undertook a range of health and safety related checks to make sure the home was safe and secure. These included fire safety checks, water quality and temperature checks and equipment testing including the nurse call system, wheelchairs and specialist beds. There was an emergency evacuation procedure. This included plans of the layout of the building, next of kin contact details and an individual assessment of each person's evacuation needs. This meant the provider had developed plans to keep people safe in an emergency.

There were systems to log any incidents and accidents and any 'untoward events' (unexpected incidents) that happened at the service. We viewed records which showed incidents and accidents had been logged. We found the information was analysed to identify trends and patterns and action was taken to keep people safe. For example, the latest analysis had identified there had been a high number of unobserved falls in the preceding month. We saw the manager had discussed his findings with staff and one person who had fallen on three occasions had been referred to the falls team for additional specialist support and advice.

Requires Improvement

Is the service effective?

Our findings

When we inspected the service in June 2014, we were concerned people did not have a pleasant dining experience during lunch. People did not always receive the consistent and uninterrupted support they needed to meet their nutritional needs. We also found people had to wait an unacceptable amount of time before receiving their food. We asked the provider to send us an action plan to tell us how they would make improvements and become compliant with the regulations. The provider gave assurances in their action plan they would meet the requirements of the regulations by 3 October 2014. This included using the 'company dining experience best practice guidelines' to improve people's dining experience.

At this visit, we found the provider had made progress with the actions they had committed to undertake. We carried out lunch time observations on both days of our inspection. When we started our observation we saw the tables had been set with tablecloths, placemats, napkins, cutlery and condiments before people arrived into the dining room. We observed that once seated in the dining room people still had to wait for their lunch, although the waiting time was considerably less than when we last inspected the service. For example, people started arriving at 12 noon with the food trolley arriving at 12.15pm.

The overall atmosphere in the dining room was calm and relaxed. Staff were present for most of the time to ensure people were supervised to keep them safe. We found people who required one to one assistance received this uninterrupted and at a pace appropriate to their needs. For example, we observed staff assisting a person with eating and saw they took their time and talked to the person throughout to reassure them. However, we observed on both days one person ate and drank very little during lunch. During our first observation the person was asleep at the table for most of the lunch time period. During our second observation this person was awake but not eating. We found staff did not provide the person with any prompts to encourage them to eat and drink something. We discussed our observations with the manager and regional manager. They advised us the person's nutritional needs would be reviewed to re-assess the level of support they required.

At other times throughout the day we saw people were offered drinks and snacks, such as at mid-morning and in the afternoon. People and family members were happy with the quality of the food. One person said, "Meals are nice, there is plenty to eat and you do get a choice." Another person said, "The food is really first class." Another person said, "The food is nice and there is plenty."

Where people had been assessed as at risk of poor nutrition, action was taken to support them to meet their nutritional needs. We viewed people's daily fluid balance and nutritional charts. We found these were being completed in a timely manner after each meal. However, we saw they were not always fully completed. For example, there was not enough information recorded to confirm whether people had met their fluid balance target for the day. The records also did not evidence the action required or taken to remedy the situation. This meant it was not possible to establish from people's fluid balance charts whether their needs had been met.

Staff were not having regular one to one supervision with their manager. Supervision is important so that staff have an opportunity to discuss the support, training and development they need to fulfil their caring role. One staff member said, "I haven't had a supervision." Another staff member told us they had an appraisal in October. They also said this was the only one to one time they had from their manager since the staff member started working at the home in July 2014. They said they had an appraisal recently but had not been receiving regular supervision. We discussed supervision and appraisal with the clinical lead. They explained they intended to introduce a system of clinical supervision for staff. We viewed a file which contained the supervision policy and procedures and a supervision plan detailing the intended list of supervisors for designated staff members. The file also included template forms for recording supervision sessions. However, these had not taken place yet. The clinical lead told us the sessions would commence sometime in November 2014.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Although staff had not been receiving regular supervision they told us they felt supported. One staff member said, "I feel very supported, the girls and the new manager are really good." We viewed training records during our inspection which confirmed most staff had completed

Requires Improvement

Is the service effective?

training that the provider considered essential to the staff member's role. For example, for care staff, this included moving and handling, dementia awareness, fire safety, infection control and safeguarding adults.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Staff did not have a sound understanding of the Mental Capacity Act 2005 (MCA) including the Deprivation if Liberty Safeguards (DoLS). MCA is a law that protects and supports people who do not have the ability to make decisions for themselves and to ensure decisions are made in their 'best interests.' It also ensures unlawful restrictions are not placed on people in care homes and hospitals. Two out of three staff we spoke with were not sure when MCA would apply to people in their care. They were also not sure whether they had completed MCA training. Staff told us and records confirmed that individual DoLS applications had been made to the local authority for particular people. For example, an application had been made for one person who wanted to leave the home but was unable to make their own decisions.

We observed staff asked people for permission before delivering care. For example, we saw people were asked to give their permission before staff supported them with moving around and before they received any care, such as receiving their medicines. On two occasions we observed staff lifting residents using specialist equipment. Both times staff explained what was happening and asked for people's permission before proceeding. We discussed consent with staff members. They confirmed they always asked people first before delivering care. They also said they would respect a person's right to refuse. One staff member said, "We cannot force a person." Staff said that if a person did refuse they would record this in their notes and go back and try again later.

Staff were able to give us examples of general strategies they used to support and manage people's behaviours that challenged the service, such as chatting with the person and distraction using activities and music. Where people had been assessed as displaying behaviour that challenged the service, we found specific care plans had been developed. We saw these had been reviewed monthly. During our observations we saw staff did not always respond quickly to support one person who was agitated. For example, we saw the person was shouting in the lounge. Staff did not intervene until the person had become agitated and the interaction was not sustained which meant the person remained agitated. It was unclear as to whether staff were aware of people's individual care plans and the specific strategies to adopt for each person, as the care plans were kept in a locked nursing office. One staff member we spoke with who had started working at the home in June 2014 told us they had not read any care plans.

Staff told us they "kept an eye" on people's general health. They said if they were concerned about a person they contacted their GP to check on them. We saw evidence within people's care records of input from a range of health professionals where this had been required. Care records included details of the contact between the home and visiting professionals. This included speech and language therapists, the falls team, the challenging behaviour team and specialist nurses. For example, staff had referred one person who did not communicate verbally, to a speech and language therapist for advice and guidance about communication. We saw the speech and language therapist person had assessed the person and a specific communication support plan had been developed. This meant staff had specific information to help them understand how the person communicated the way they were feeling. During our inspection we saw an optician visiting the home to see a person who was having difficulty with their eyesight.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us they were happy with the care they received. One person said, "I am very happy here." Family members told us their relatives received good care. One family member said, “Care in this home is excellent.” They told us about how [their relative] was treated “with dignity and respect.” They also said, “Care was exceptional. [My relative] was always clean, tidy and well-presented and their hair and nails always clean.” Another relative said, “I find the staff very caring people and supportive. [My relative] is always well-presented, clean and tidy, and the staff keep me updated on how she has been.” Family members said they were kept informed about changes to their relative’s care. One family member said, "Staff keep you well informed and consult you on care decisions.”

We carried out a specific observation in the lounge on the dementia floor using SOFI. During the 40 minutes of our observation we found most people received one to one interaction from staff to varying degrees. For example, one person spent time with a staff member having their nails manicured, chatting and looking at CDs whilst other people had a brief chat with staff. We found staff were kind, caring and considerate towards the people in their care and people responded positively to the interaction. At other times throughout the day we observed staff interacting with people. We saw this was always done in a professional and friendly manner.

We observed two occasions where staff did not respond to people’s needs in a timely manner. We saw one person was becoming increasingly agitated in the dementia lounge. We also saw it was only when other people began to shout back at this person that staff intervened. On another occasion we heard one person in their room close to the lounge was shouting for a considerable period of time. We found it was only after we prompted staff that they went to see to the person’s needs.

Staff had a good understanding of people’s preferences including their likes and dislikes. Staff said they looked in people’s notes and care plans to find out about them. We observed staff chatted with people about things that were important to the person. For example, we saw staff talking with people about their family life and family members.

People had access to information about independent sources of advice and guidance. We saw information for people and their family about advocacy was displayed in the reception area. We also saw people had a leaflet about advocacy in their bedroom to refer to.

Staff understood the importance of maintaining people’s dignity and respect. They gave us practical examples of how they delivered care to achieve this aim. For example, keeping people covered up as much as possible when giving personal care, shutting the door when people were using the toilet, taking people to their own room when supporting them to change their clothes and maintaining confidentiality. We observed staff talking to people and found they were respectful and polite. They asked people if they were okay and if they needed anything. For example, we saw staff continually talked to people asking if they had slept well and had enjoyed their breakfast.

Staff described to us how they promoted people’s independence. One staff member said, “We try to keep them [people] as independent as possible. We don’t take things away from them. Some people like to do things themselves.” Staff gave us examples of choices people were supported to make on a daily basis. These included what clothes they wanted to wear, food choices and whether they wanted to go out or stay in.

We spoke with staff about the care they delivered to people and we particularly asked them to tell us what the service did best. They commented, “Caring and looking after our residents”, “We have a good care team”, “Providing good care”, and, “Staff are very friendly towards the residents.”

Requires Improvement

Is the service responsive?

Our findings

When we inspected the service in June 2014, we were concerned people did not receive the support they needed to meet their social needs. In particular, there was a lack of social interaction and no evidence of a structured activities programme. We asked the provider to send us an action plan and tell us how they would make improvements and become compliant with the regulations. The provider gave assurances in their action plan they would meet the requirements of the regulations by 3 October 2014. These included developing an individual social activity record for each which identifies their preferences for their social life, a record of daily interactions and support for people to achieve their social goals and preferences and training in conflict resolution, dementia and DOLS.

At this visit, we found the provider had made progress with the actions they had committed to undertake. A new activities coordinator had been employed. We found the activities co-ordinator was trained in care and was soon to start a qualification in dementia care and attend a day conference specific to developing skills in providing meaningful activities for people living with dementia. Staff told us the provider planned to employ an additional staff member to support the work of the activities co-ordinator.

We saw a weekly activities programme had been developed and was displayed in the reception area. We did not observe any specific group activities happening during our inspection. However, there was evidence in the records that planned activities took place. For example, records showed residents took part in group activities in and out of the home on a regular basis. These included bingo sessions, watching films and organising entertainers to visit the home. The home had the use of a minibus to take people on outings. A small group of residents including one person living with dementia visited Beamish Museum recently. Other people had visited local shops. We saw photographs highlighting the visit on the activities notice board. People were escorted to the local shops and to the park to feed the ducks. There were also records of one to one activities with residents. These included brief discussions, hand massage and listening to music. One family member said, “There is plenty going on but [my relative] prefers to stay in her room so staff go to her room and talk to her and do her nails.”

People were supported to make choices about what they wanted to do. For example, we saw they were asked if they would like to join in an activity, watch TV or read. Although there were no organised activities on-going during our inspection, staff gave us examples of the things people could take part in. For instance, spend time in their room or the lounge, play games, painting or watching a film. Staff said they tried to give people one to one time. One staff member said, “We try and do as much as we can.” They told us one to one time usually included hand massages, manicures and chatting.

People’s care records were well organised and contained relevant documentation, such as assessments and care plans. People had their needs assessed when they moved into St Cuthberts. We found care plans had recently been updated to reflect people’s current needs. Care plans we viewed were person centred and contained details of people’s preferences including their likes and dislikes. We saw within care records that people had a ‘This is me’ personal profile and ‘My Day.’ This provided staff with a summary of people’s needs and important things they needed to know about the person. For example, food likes and dislikes, people’s interests and hobbies and their preferred daily routine. Staff said people and their family members were involved in gathering this information. This meant staff had personal information to refer to about each person to help them better understand their needs.

We found the clinical lead and qualified nurses evaluated care plans monthly. However, we found records of previous evaluations needed improving as they did not provide a meaningful update and did not directly link with people’s care plans. We also found there was no evidence in the care records of a robust multidisciplinary review meeting that included family or other professionals. We saw evidence staff had reviewed people care files every six months. However, the record of the review mainly consisted of the date the review was done and the next planned review date. There was no record of the findings from the review and whether the person’s care plan was working or needed to be changed. We discussed this with the clinical lead who told us this was a priority area for the service to develop.

The provider told us in their action plan that they would introduce monthly resident’s and relative’s meetings and carry out a resident’s and relative’s survey. We found during this inspection opportunities for people and family members to provide regular feedback about the service

Requires Improvement

Is the service responsive?

were being developed. We also saw 'relative's meetings' had recently been introduced. We viewed the minutes from the most recent meeting which took place in October 2014 and saw relative's views had been captured. For example, relatives had suggested ideas for activities and redecoration and refurbishment of the communal lounges. The relative's meeting was also used to feedback changes to care practice. For instance, the changes made to the dining experience, particularly 'staff to sit and eat with residents to help with interaction to improve the experience.' We saw details of the November meeting had been displayed around the home.

Nobody we spoke with could recall being sent a survey or questionnaire to ask them for their opinion about the home or the quality of the care. However, we viewed the feedback from previous questionnaires that had been received from family members. We saw there had been ten questionnaires returned. However we were unable to establish when they had been received as they were not dated and were from before the new management team started. Feedback was generally positive although some areas for improvement had been identified. For example, five out of ten relatives rated the activity programme as poor. They commented, "Wish some form of entertainment could be arranged", "Residents are just sitting all day every day, doing nothing at all", "No activities for residents and not enough staff to look after the residents on [dementia unit] floor. Family members also made some negative comments about the décor in the home, "Lounge is in a poor state of repair", and, "The condition of the dementia unit is poor."

Requires Improvement

Is the service well-led?

Our findings

When we inspected the service in June 2014, we found audits had not been successful in identifying shortfalls in the quality of people's care records, such as position change charts and food and fluid charts. We also found medicines audits had not been successful in identifying gaps in people's MARs. We asked the provider to send us an action plan to tell us how they would make improvements and become compliant with the regulations. The provider gave assurances in their action plan they would meet the requirements of the regulations by 3 October 2014.

At this visit, we found the provider had made progress with the actions they had committed to undertake. These included introducing monthly 'staff meetings', weekly medicines audits and monthly company internal and external quality assurance checks. We viewed the record of the first weekly medicines audit that had recently been completed. We saw this had been successful in identifying issues and ensuring that action was taken to prevent the situation happening again. For instance, staff had not been countersigning a daily MAR checklist and some people's photographs needed to be updated.

Staff meetings were now held regularly. We viewed the minutes from previous meetings which showed the meetings were used to raise staff awareness of care practice and procedures. For instance, reminding staff to check people's care records to remind them of people's likes and dislikes and to encourage staff to interact with people and offer activities. The format of the minutes had recently been changed so that specific actions were documented to make it easier to follow them up. Actions identified included additional training for staff and changes to enhance people's dining experience.

The service did not have a registered manager. The manager and clinical lead were both new to the service and had been in post for three and five weeks respectively. We found they were still settling into the service and their role and were not yet fully orientated to the geography of the service and the environment. For example, they often found it difficult to remember where rooms were situated and where certain files could be found. We observed the manager regularly walked around the home speaking with people and checking they were alright. Staff told us the manager and clinical lead were supportive and approachable. Staff said, "Management are great, really nice both of them. They are always around on both floors", and, "[clinical lead and manager names] will do a good job. If I want to talk to them I feel able to do that." Staff also said they loved working at the home because of "the nice atmosphere and support given."

We found the provider's values were not embedded into care delivery at St Cuthberts. The provider had specific values it expected staff to work to. We asked staff about these values when we spoke with them. None of the staff knew about these values or could tell us what they were. Staff commented, "Not aware", and "Don't know."

The provider had a system of checks and audits as part of its quality assurance programme to assess the quality of care provided. This included a registered manager's monthly 'quality checklist' which included audits of the kitchen, dining room, laundry and people's care records including care plans and risk assessments. However, we found because of a number of changes to the management team over recent months these had not been effective in driving forward improvements. For example, issues and concerns that had been identified during previous audits had not been signed off as complete or carried forward into subsequent audits.

The regional manager also undertook a monthly audit. We viewed the most recent audit available which had been carried out in October 2014. We saw actions had been identified from the audit which included reviewing and updating care plans, completing food and fluid charts in real time and setting up 'resident's meetings.' The tool used to record the regional manager's audit had a section to provide an update on previous issues or concerns. We found no update had been recorded as the regional manager was new in post and this had been their first audit as regional manager. We discussed this with the manager and regional manager. They told us the quality of audits would now improve as there was a new settled management team in post.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The provider did not have suitable arrangements in place to ensure staff were appropriately supported to enable them to deliver care and treatment to people because they were not receiving regular supervision. Regulation 23(1)(a).**