Gainford Care Homes Limited

Lindisfarne CLS Nursing

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Lindisfarne Chester-Le-Street Nursing provides accommodation for up to 53 people who require nursing and person care. At the time of inspection there were 39 people using the service, 38 of whom required nursing care. The home has two floors; both floors have bedrooms, lounges and dining rooms.

At the last inspection, the service was rated as 'Good' overall. We found a breach of Regulation 12 (Safe care and treatment); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and asked the provider to make improvements in relation to maintenance. During our inspection we found the improvements had been made.

The service had a registered manager in post. 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.

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

People received their medicines in a safe manner. We found there were appropriate arrangements in place for the receipt, storage and disposal of people's medicines.

We observed staff respond promptly to meet people's needs. Staff told us there were enough of them on duty to give people the support they needed.

Staff had assessed the risks to individual people living in the home. Risks assessments documented the nature of each risk and the actions staff were expected to mitigate the risks.

People were given a choice of menu each day. Staff supported people to eat where necessary and provided prompts to others to encourage them to eat. People's personal weights in the home remained stable. We saw if a person had lost weight action was taken so they could be reviewed by a dietitian.

Partnership arrangements were in place with local GPs and a Community Psychiatric Nurse who both visited the home on a regular basis to review people's health care needs. The services of chiropodists, opticians and the Speech and Language Therapy (SALT) Team were sought by staff to ensure people's needs were met.

We found staff were caring and respectful towards people who lived in the home. Personal care was carried out behind closed doors to protect people's dignity and privacy.

Care plans were detailed and person centred. Staff demonstrated they knew people well and gave us information about people living in the home. We saw care plans were reviewed each month to ensure they

were accurate and up to date.

Complaints made about the home had been investigated by the manager and appropriate responses were given to the complainants.

The registered manager and the two regional managers who supported the service regularly audited the service and addressed any deficits they found. The audits included visits by the registered manager during the night to monitor the service provided. A remedial action plan was kept by the registered manager. When an improvement was identified this was added to the plan; target dates for actions were set and the improvements were made.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was Good.

Arrangements were in place to address maintenance issues in the home. We found the home was well-maintained.

Risks for individual people and in the home had been assessed. Actions had been put in place to diminish the possibility of accidents and incidents occurring.

People's medicines were stored and administered in a safe manner.

We found there were sufficient staff on duty to meet people's needs.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

Lindisfarne CLS Nursing

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 checked 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 was a comprehensive inspection.

This inspection took place on 26 July and 2 August 2017 and was unannounced.

The membership of the inspection team consisted of one adult social care inspector, a specialist advisor to the Commission with a background in nursing and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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. A notification is information about important events which the service is required to send to the Care Quality Commission by law. We contacted professionals involved in caring for people who used the service; including local authority commissioners. Professionals told us they had no concerns about the 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 PIR and used it to inform the planning of our inspection.

During our inspection we spoke with three people who used the service and two of their visiting relatives. We carried out observations of people who could not speak for themselves and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed seven care files and other records which demonstrated how the regulated activities were being met. We spoke to 14 staff including regional managers, the registered manager, the deputy manager, senior care staff, care staff, agency staff, activities coordinator and kitchen staff. We also checked the building to ensure it was clean, hygienic and a safe place for people to live.

Good

Is the service safe?

Our findings

When we spoke to people and asked them if they felt safe, they responded with positive comments. One person said, "I like it here" and "I like my bedroom". We carried out observations of people who were unable to speak for themselves and found people approached staff with confidence.

At the last inspection we judged there was a breach of Regulations 12 (Safe care and treatment); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider did not have sufficient arrangements in place to monitor the maintenance of the home. At this inspection we found the registered manager had in place daily maintenance checks and audits on the building to monitor the safety of the home environment. Staff had access to a system to report maintenance issues to tell the maintenance staff about the repairs needed. We found the building was well-maintained.

During our inspection we saw emergency pull cords were not available to people who may have fallen on the floor. The registered manager immediately rectified the situation and we saw the pull cords were replaced. On the second day of the inspection we found some of these had subsequently gone missing. The registered manager explained it was possible people had removed them. In order to ensure regular checks were maintained, the registered manager added this to the maintenance person's daily checklist.

Regular fire checks and water checks were carried out. We found risk assessments had also been put in place in relation to the building. The risk assessments detailed actions on how to keep people safe in the home. People had personal risk assessments in place including for example, falls risk assessments and moving and handling risk assessments. Staff had identified personal risks to people and put in place actions to mitigate the risks. When we spoke to staff about people's needs they were able to identify the risks and knew what action to take.

Monthly analysis of accidents was carried out by the registered manager using an electronic system. The system showed the number of accidents, which person had the accident, the type and where the accidents took place. This enabled the registered manager to identify if any actions needed to be taken to prevent reoccurrences.

People's medicines were safely managed. We found medicines were stored in locked cupboards and trollies. We looked at the medicines administration records (MAR); all of the MAR charts, had photographs of people for identification purposes, along with any allergy information. Instructions for the administration of people's medicines were also documented. Suitable arrangements were in place for the receipt and disposal of medicines. Controlled drugs are those which are regulated under the misuse of drugs legislation. We carried out a check on the controlled drugs held by the home and found no discrepancies. At time of inspection we found two people were receiving their medicines covertly. Staff informed us of the procedure regarding covert medication including making a decision in the person's best interests. Care plans were in place which described the best interests decisions and how people were to be given their medicines.

The registered manager told us, given the high level of needs of the people who used the service, the

provider had agreed to increased levels of staffing. We found there were enough staff on duty to meet people's needs. We observed there was always a staff member present in lounges and dining rooms whilst people who used the service were present. Staff were able to respond promptly to situations to prevent them from escalating into safeguarding concerns. When asked about staffing levels, one member of staff told "It's running smoothly" and they believed the service had enough staff to meet people's needs.

We looked at staff recruitment records and saw that appropriate pre-employment checks had been undertaken. Staff had completed an application form detailing their past employment and training. Disclosure and Barring Service (DBS) checks were carried out and two written references were obtained. 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. Nurses employed by the service were registered with the Nursing and Midwifery Council.

We saw staff had received training in safeguarding. Staff confirmed they had received the training and certificates were on staff files which validated their training. All staff we spoke with told us they would be confident to report any concerns they had about a person or a staff member to the registered manager. One staff member said, "I would report something soon as I could to avoid anything happening". The registered manager maintained a log of safeguarding incidents and documented lessons learnt from each incident.

Good

Is the service effective?

Our findings

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2006 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff had assessed people's mental capacity and made appropriate applications to the local authority to deprive people of their liberty and keep them safe. Staff were able to tell us about capacity, we found they had received training in this area. We found the service complied with the requirements of the MCA and DoLS.

Every member of staff we spoke with told us they had an induction. The induction methods varied according to when staff members joined the service. We saw staff had shadowed more experienced members of staff and had worked through an induction booklet. Staff were also supported through training. Recent training included the moving and handling of people, nutrition awareness, palliative and end of life care and equality and diversity. We found staff met with their manager at regular intervals for supervision. In addition the manager had used group supervision as a means of supporting staff to learn about specific issues.

During our inspection we passed our concerns onto a staff member about one person who had just spoken to us and become distressed as they remembered their past life. The staff member immediately followed the person and distracted them to reduce their distress. We observed staff working with another person who was displayed challenging behaviour toward them. Staff managed the situation to good effect. We found staff were skilled in working with people who challenged the service.

Entry to the home was via an intercom system and entry to the upper floor was by keypad, on doors and the lift. There was a gate at the bottom of the main staircase to prevent people from climbing the stairs. Adaptations to the building had been made to support people's orientation in the building. Doors were painted different colours with signage to allow people living with dementia to retain their independence. Themed corridors supported people's movement around the home. Toilet seats were dark blue to enable people distinguish the toilet in light coloured bathrooms.

Kitchen staff were aware of people's dietary needs and had arrangements in place to order, cook and serve meals for people who required specialist diets. People had nutritional assessments in place. We observed a meal time where one person did not want to sit down for their lunch. Staff offered them finger food so they could walk around and eat if they wished. Menus had recently been changed; we saw the menus offered people choices and provided them with a balanced diet. Staff supported people who needed help to eat and drink. Drinks were offered to people on a regular basis. We saw the drinks trolley included snacks and milkshakes to prevent people from losing weight. The registered manager told us they wanted to avoid missing weighing people and asked people to be weighed every week. We looked at the weekly weights and found people's weights had remained stable. Where people had begun to lose any weight, referrals had been made to the dietitian and dietary supplements were provided to people. The supplements were stored

in treatment room, and were in date.

Staff informed us a local GP visited every Tuesday, to discuss any issues concerning people's health. They also made contact with the surgery on an as required basis. A Community Psychiatric Nurse [CPN] visited on a monthly basis and was available by telephone contact. The CPN was able to refer people to a consultant psychiatrist, if required. There was evidence that people received eye checks from the local optician. Dietary advice had also been provided by the Speech and Language Therapy Team. This meant staff enabled people to have contact with health professionals to maintain their health.

Good

Is the service caring?

Our findings

One relative said, "I know they will take good care of him here". Another relative said, "I get along well with the staff. "One staff member said, "This is one of the friendliest homes I've worked in." Another staff member said, "This is a very friendly home; the staff are lovely". The home had received cards to say, "Thank you" to staff for the care and attention their relatives had received whilst living in the home.

Staff treated people with care and respect. We observed staff listening to people as they spoke about their past history. When talking to people, staff sat face to face or knelt down to they could engage with people. One staff member said, "I think dignity and privacy and choice are very important." We saw staff knocked on people's doors before entering their room. Personal care was carried out behind closed doors.

Staff spoke to us in detail about people's needs. They described to us people's likes and dislikes and demonstrated they knew people well. We observed one member of staff providing support to colleagues and giving them information on how people's needs were to be met. Staff were able to see the signs of people becoming distressed and intervened to prevent situations from escalating.

We saw relatives had been involved in the design of people's individual care. Relatives we spoke with confirmed they had been asked questions. This meant people's care needs were informed by people who knew them best. The registered manager had also held relatives' meetings to include relatives' participation in the home.

Although there was no one in the home who was on end of life care, we saw end of life arrangements had been discussed with people and their relatives. People had, "Do not attempt resuscitation documents in place." These documents instructed staff not to attempt cardiopulmonary resuscitation should a person stop breathing.

People's care documentation was stored in locked offices to protect their confidentiality.

Good

Is the service responsive?

Our findings

One person told us they did not want to live in a home, but since they had, it had been a good decision as they could not manage at home. The person told us, "The staff were are good", and they were "Looked after well."

Before people began to live in the home, we saw the registered manager carried out an assessment of their needs. The registered manager explained the challenges of working in a service where people had complex needs and was keen to ensure any new admission to the home did not place any undue stress on the staff group or significantly alter the dynamics of the existing group of people who used the service resulting in stress and agitation. To this end, they had refused to admit some people who were referred to the home.

All care files we viewed had details about the person's past life, including a document entitled "All about me" which documented the relationships important to people. This meant staff were aware of people's past lives and could relate to the conversations people initiated about their family or their previous working life.

People's care plans were comprehensive and person centred. This meant they were focused on each individual. For example, one person told us on some days they were not always hungry and some days they were able to eat more. We saw this detail was recorded in their care plan. People had communication plans in place and where people were unable to express themselves verbally; we saw staff had documented how people expressed positive and negative responses. People's care plans included guidance to staff on a range of care needs pertinent to each individual. These included sleeping arrangements, nutrition and hydration requirements and continence needs. We saw where people were living with dementia, plans showed how each person's dementia affected them and what actions staff were to take to prevent people from becoming distressed.

Each person's care plans were evaluated every month. Staff reviewed the plans and documented if a person's needs had changed.

We spoke with the registered manager about transitional arrangements in place to ensure if, for example, a person needed to attend a hospital and how information was shared with medical staff to ensure the person received appropriate care. They told us when a person went to hospital; the service sent a copy of the "This is Me" document together with information about the Herbert protocol, their MAR sheet and a handover sheet from the nurse which explained the person's symptoms. The Herbert protocol is a national scheme where people who may go missing are already registered with the police. If a person goes missing, the police can immediately circulate their details.

The registered manager told us they had experienced difficulties in recruiting an activities coordinator to the post. A new coordinator had recently been appointed from within the service. We saw there was an activities board in place which showed people what activities were being carried out that day. We saw where people were unable to engage in group activities, individual time was spent with them.

We carried out our Short Observational Framework for Inspection (SOFI) to observe people's engagement in activities. We observed a staff member engage a person looking at a local history book. Another person was using a tambourine and laughing and smiling. A third person was in conversation with a member of staff whilst colouring in a book and chatting about its contents. This meant people were engaged in activities specifically for them. Activities were recorded each day. The activities coordinator explained they were getting used to their role and what worked with each person.

We saw the provider had a complaints policy in place. Complaints which had been made to the service were documented and investigated. Outcomes of the complaints were given to the complainants; these included explanations and where appropriate an apology.

Good

Is the service well-led?

Our findings

The service had in place a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff told us they felt confident in the registered manager to take action. One staff member said, "The manager and senior managers are very supportive". Another staff member said, "Most staff have a good morale and work well as a team".

The registered manager conducted monthly audits to monitor the quality of the home. These included kitchen, medicines, and bed rail audits. Actions to improve the service which were identified during the audits were added to an on-going remedial action plan which was monitored by the regional managers. The actions included changing menus and employing an activities coordinator to provide stimulating activities for people in the home. We found actions had been addressed and completion dates were documented. This meant the service had a continuous improvement plan.

Each week the registered manager was required by the provider to complete a risk monitoring report about the home. The report included accountability for people who may have lost weight, safeguarding incidents in the home, and people who were subject to DoLS.

The registered manager provided direction in the service. We saw they chaired staff meetings and held flash meetings. These are meetings which are held with the staff on duty to pass information on to staff for immediate action. The registered manager had also used group supervision as a vehicle for driving improvement in staff practices including for example the disposal of continence products to reduce risks of cross infection.

We found the registered manager had visited the home during the night to carry out checks. These were documented and described the findings. Following these night visits the registered manager had addressed areas with staff which needed further improvement. This included ensuring documentation was updated hourly.

Surveys of people who used the service and their relatives had been carried out to monitor the service quality. We saw the responses were largely positive.

Regional managers carried out monthly visits to oversee the actions of the registered manager and review the audits which had been carried out. They also audited people's files and staff personnel files.

The registered manager chaired staff meetings and held flash meetings. These are meetings which are held with the staff on duty to pass information on to staff for immediate action. The registered manager had also used group supervision as a vehicle for driving improvement in staff practices.

During our inspection the registered manager and two managers reflected on the improvements they had made in the service to develop a positive person-centred culture in the home. They spoke about recruiting the right staff and addressing the deficits they had found in the home when they took over the service. Staff echoed the registered manager's reflections. One staff member told us since the registered manager had taken action, the home had improved. They now felt comfortable coming to work.

The registered manager had submitted the notifications to the Commission as required. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. The service was displaying their CQC rating in the home and on their website.