Solehawk Limited

Craigielea Nursing Home

Inspection report

739 Durham Road
Gateshead
Tyne And Wear
NE9 6AT

Tel: 01914874121
Website: www.craigieleacare.co.uk

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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?	**Inadequate**

Summary of findings

Overall summary

The first day of this inspection took place on 25 September 2017 and was unannounced. This meant the provider did not know we were coming. We also visited the home on 29 September and 4 October to finalise our inspection.

In December 2016 we carried out an inspection of this home and found three breaches of regulation. These related to equipment not being safe for use or used in a safe way, infection control management and unsafe management of medicines. The provider had failed to ensure there were suitably qualified, competent and skilled staff deployed to provide care, support and treatment. We found the provider had not ensured systems and processes were used effectively to assess, monitor and improve the safety of the services provided.

This inspection was also prompted in part following concerns raised by the local authority commissioners regarding care and support, record keeping, lack of consistent nursing staff and ineffective leadership within the service.

Craigielea Nursing Home provides accommodation, nursing and personal care for up to 64 people including those living with dementia. The service was supporting 46 people at the time of this inspection.

The service does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. A registered manager is a person who has registered with the Care Quality Commission (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 service had a manager who commenced employment in March 2017 and was still in their probationary period. The provider told us the manager intended to submit an application for registration with the Commission. Following the inspection the provider informed us that the manager had left the service. The operations manager was supporting the service until a new manager was employed.

On the first two days of the inspection the manager was on planned annual leave, we were supported by two interim managers from the provider's neighbouring locations and the operations manager. The operations manager was also available on the second and third day of the inspection. The manager had returned to work on the third day of the inspection. Following our inspection the operations manager sent us information to confirm that the manager had left the service. The operations manager told us they were overseeing the service until a new manager was recruited.

At this inspection we found that there were breaches of four of the Fundamental Standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safe delivery of care and treatment, safeguarding, staffing recruitment and the overall oversight of the home.

Medicines were not always managed safely. We found gaps in the recording on the medicine administration records (MAR). Where people were prescribed 'as and when medicines' protocols for such administration were not readily available for staff when administering medicines. The provider did not have topical MARs in place for staff guidance and support when administering topical medicines. Topical medicines are creams or ointments applied to the skin.

One treatment room which contained medical dressings and other equipment used to care for people requiring nursing care was unlocked. We found sharps (such as needles) stored in cupboards which were also unlocked.

The provider had not identified some incidents as potential safeguarding concerns and had not acted appropriately to ensure people were safe.

Risks to people had been assessed, however some assessments contained conflicting information.

The provider had failed to ensure staff were suitably competent and skilled to provide care support and treatment. The provider had a reliance on agency staff to cover shortfalls in nursing positions. The provider made requests for consistent agency staff when contacting the agency. Staff had not received regular supervision or appraisal. Nursing staff had not received any form of clinical supervision. Following our inspection the operations manager sent us information to confirm that a clinical lead had commenced employment in the home to provide support to nursing staff.

Training was out of date for some staff in certain subjects. We found gaps in the training for specific subjects such as Percutaneous Endoscopic Gastrostomy care (PEG) and diabetes. PEG is a tube which is passed into the stomach to provide a means of feeding when oral intake is not adequate. Training had been planned for nursing staff to cover these areas as part of the service's action plan. Following our inspection the operations manager sent us information to confirm that training in PEG had been completed by all nurses.

Although people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way. We found the provider did not have a robust system of monitoring the timeliness of people's applications for renewal of Deprivation of Liberty safeguards (DoLS).

People's care records were not always personalised, or contained detail for staff to follow to ensure safe support and guidance. People's preferences regarding activities, hobbies and interests were not always captured. Records in relation to people's health and nutritional needs were not always completed fully and there was no evidence of oversight regarding monitoring of these records.

We have made a recommendation about the provider's approach to care records.

The provider had a complaints policy and procedure in place. We found the provider had not always notified complainants of the outcome of their complaint.
We made a recommendation about the management of complaints.

Statutory notifications were not submitted to CQC in a timely manner. People's personal records were not held in line with the Data Protection Act.

Quality assurance processes were not effective in assessing, monitoring and improving the service. We found the quality assurance process had not highlighted some of the concerns raised at this inspection. The records relating to provider visits did not demonstrate a consistent approach.

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

People and relatives who used the service were complimentary about the standard of care at Craigielea Nursing Home. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves whenever possible.

The provider ensured appropriate health and safety checks were completed. We found up to date certificates to reflect fire inspections, gas safety checks, and electrical wiring test had been completed.

A business continuity plan was in place to ensure staff had information and guidance in case of an emergency. People had personal emergency evacuation plans in place that were available to staff.

At the time of the inspection the provider was working with the local authority and had developed a comprehensive action plan to drive improvement in the home.

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.

Medicines were not managed in a safe manner. Staff had not had their competencies to administer medicines checked.

Risk assessments were not always accurate and contained conflicting information.

The provider used a dependency tool to ascertain staffing levels, this was reviewed on a regular basis to ensure an appropriate number of staff were on duty.

The provider ensured health and safety checks were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was not up to date. Some staff had not received the appropriate level of training to support people with complex needs.

Following our inspection the operations manager sent us information to confirm that nurses had completed training in PEG.

Staff did not receive regular supervision in order to support them in their roles.

People enjoyed a varied and health diet. Kitchen staff were aware of people's nutritional needs

Is the service caring?

Requires Improvement

The service was not always caring.

We found the language used in the care records did not always promote the dignity of people living with dementia.

Staff demonstrated a caring and supportive approach to people. People's privacy and dignity were respected.

People and relatives felt the service was caring.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always person centred, people preferences were not always recorded.

Activities were not always tailored to people's individual needs.

People were aware of how to raise a complaint. However we found complainants were not always responded to.

The provider held regular meetings for people, relatives and staff.

Is the service well-led?

Inadequate

The service was not well led.

The service did not have a registered manager. The manager at the service had not submitted an application to CQC. Following our inspection the operations manager sent us information to confirm that the manager had left the service.

The systems and processes in place to monitor the quality of the service had not identified the shortfalls found at this inspection.

The provider had failed to submit statutory notifications.

People and staff made positive comments about the managers.

Craigielea 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.

The first day of this inspection took place on 25 September 2017 and was unannounced. This meant the provider did not know we were coming. We also visited the home on 29 September and 4 October to finalise our inspection.

The inspection was carried out by two adult social care inspectors on the first day of day of the inspection. The second and third day of the inspection was carried out by one adult social care.

Before the inspection we reviewed other information we held about the service and the provider. This included previous inspection reports and statutory notifications we had received from the provider. Notifications are changes, event or incidents the provider is legally obliged to send to CQC within required timescales. We contacted the local Healthwatch team and obtained information from the local authority commissioners for the service, the local authority safeguarding team, the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with six people who lived at Craigielea Nursing Home. We spoke with the operations manager, two interim managers, the manager, four nurses, (two who were from an agency) two senior care workers, five care workers. We also spoke with three visitors or relatives of people who used the service.

We looked around the home and viewed a range of records about people's care and how the home was managed. These included the care records of six people, the recruitment records of four staff, training records and records in relation to the management of the service.

Requires Improvement

Is the service safe?

Our findings

When we last inspected Craigielea we found the home was not safe and the provider had breached Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The provider had not ensured the equipment used by the service for providing care or treatment was safe for use and used in a safe manner. The risks regarding infection control had not been assessed. The provider had not ensured the safe management of medicines.

Before our visit we found the provider had commenced an audit of the management of medicines within the home and had identified some areas which required action. The provider had raised two safeguarding alerts with the local authority and submitted two statutory notifications to CQC when they had found medicine errors. The interim manager told us, "I have concentrated on the nursing side first and have set up a system of monitoring medicines management."

We reviewed the medicine administration records (MAR) and found some gaps in signatures. Where people were prescribed "as and when" medicines, the MAR file did not contain protocols for staff support and guidance to ensure people were offered these medicines appropriately.

Where people were prescribed topical medicines, the provider did not have any record of who had applied the medicine. Topical medicines are creams or ointments applied to the skin. Staff had a tick box to indicate the topical medicine had been applied. Body maps were not available to provide support and guidance to staff on where to apply the cream.

We found prescribed creams and ointments, which if ingested or used incorrectly could cause potential harm to people, were not safely stored. For example, in one en-suite shower room, on an easily accessible shelf, we found Hydromol ointment (prescribed for the management of eczema) with a contraindication 'avoid eyes'. In the en-suite bathroom of another bedroom we found a prescribed cream called Phorpain gel. This gel was for 'external use only' and should not be used if a person is allergic to ibuprofen, or aspirin or other pain killers. There were no risk assessments in place to demonstrate the storage of medicines in people's room had been assessed as safe practice.

We examined records pertaining to temperature recordings for the fridge used to store medicines which needed to be kept at a certain temperature. We found gaps in the daily recording.

Staff had not received competency checks to demonstrate the provider had checked to ensure staff administering medicines were safe to do so.

We found the provider had a reliance on agency staff to cover nursing hours. The manager told us they booked the agency staff ahead of time to ensure consistency of agency nurses, however this was not always possible. We found the provider had developed detailed handover sheets to provide support and guidance for all staff. Two agency nurses we spoke with told us they had a full verbal handover at the beginning of their shift and were aware of the handover sheets. Following our inspection the operations manager sent us

information to confirm that a clinical lead had commenced employment in the home and was providing clinical support for nursing staff.

We found that risks to people with complex needs were not managed effectively. We found a nutritional risk assessment had been completed for one person where they had attained a score of 14 and assessed as being 'at risk'. We found a second nutritional screening tool in the same person's care plan assessed them to be at low risk. Such conflicting information places people at risk of malnutrition. Another person's risk assessment for skin integrity did not take into account their mobility status. A third person's risk assessment for continence did not detail interventions for staff in order to clean the skin effectively. This meant we could not be sure risks to people were being assessed accurately and appropriate interventions to reduce risk were available to staff.

We found the manager kept a safeguarding file. The file contained several safeguarding alerts raised by the local authority with a request to investigate and feedback to the authority. We discussed these with the local authority safeguarding team who told us they had not received feedback from the provider on the investigations. None of these incidents had not been raised with us as statutory notifications.

The 'treatment' room on the ground floor, which contained sharps and was easily accessible, was left unlocked. This was addressed on the day of the inspection.

Where people living with dementia were accommodated we saw appropriate standards of cleanliness and hygiene in relation to the premises were not maintained. This exposed service users, persons employed and others to health care associated infection. For example, in bedrooms we found the arms and seat covers of chairs were stained with what we assessed to be food, dirt and body fluids. We found a pressure mat, which was used to alert staff if a service user got out of bed during the night, which was heavily stained with dirt, debris and body fluids. In two of the bedrooms we saw that, although the beds had been made, the sheets were stained with white marks.

The home was divided into three units, one area for people living with dementia, one for people with general nursing care needs and one area for people with 'residential' care needs. We saw substantial refurbishment had taken place in many areas of the home. For example, new carpets and lighting in communal areas on the ground floor as well as improvements to the kitchen. However, this refurbishment had not extended to the area where people with dementia were accommodated. In this part of the home we saw carpets in communal areas and bedrooms were badly marked and stained. There was a strong unpleasant odour in the corridors and communal lounge area, with the paintwork in people's bedrooms being chipped and worn.

These findings demonstrate a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

During the inspection we identified that a potential safeguarding concern had not been investigated or reported to the local safeguarding authority or to CQC. We asked the interim manager if they could demonstrate that an investigation had been carried out in relation to this. They could not confirm this and took immediate action to address this failing. This demonstrated that suitable arrangements to ensure people were safeguarded against the risk of harm by means of responding appropriately to any potential incident of abuse were not in place.

These findings demonstrate a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Due to the concerns raised by the local authority the provider had developed an action plan to drive improvement in the home. We found that since the implementation of this action plan work had been undertaken in relation to medicine management, we saw an increase in nursing staff to support people's complex health needs. We saw work had commenced on people's risk assessments being reviewed to ensure effective control measures were in place to reduce risk. The cleanliness of the home formed part of the action plan. We found some areas had already been addressed with areas being deep cleaned. Statutory notifications were now being submitted in a timely manner. The operations manager told us, "The local authority are happy with the plan and could see some improvements." They went on to explain the local authority plan to visit the home again in two weeks.

The operations manager told us they had completed a full review of staff personal files to check recruitment procedures. The audit identified one staff member did not have evidence of a Disclosure and Barring Service (DBS) check. The staff member was suspended from work whilst this was addressed by the operations manager and a new DBS requested. Disclosure and Barring Service checks that prospective staffs were able to work with vulnerable adults and that they could do so without restriction.

The staff files we examined contained all necessary checks were made before the staff had commenced employment. For example, two references and disclosure and barring service checks (DBS). These were carried out before potential staff were employed to confirm whether applicants had a criminal record and were barred from working with vulnerable people.

We found checks had been made on equipment used by staff to support people with their mobility needs. Equipment used to provide percutaneous endoscopic gastrostomy (PEG) feeds was clean. A PEG is a tube which is passed into a person's stomach to provide a means of providing nutrition when oral intake is not adequate or possible.

On the day of the inspection two care workers were providing support and care for nine people living with dementia. One senior care worker, three care workers and an agency nurse were providing support and care for the remaining thirty people in the building, 21 of who had been assessed as requiring nursing care.

The senior care worker on duty was responsible for the administration of medication to all people in receipt of residential care, including those people living with dementia, who were accommodated over two floors of the home. We asked them their views about staffing levels and the time it took them to administer medication. They confirmed that they found them to be sufficient to allow them the time needed to complete this task safely. We asked another member of care staff about staffing levels in the area of the home where people living with dementia were accommodated. She said "You're never on your own when you're working in here. There are always other staff popping in and out." A visiting relative said, "They (the provider) have been getting a few more staff in lately."

At the previous inspection the provider breached Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The registered provider had used a dependency tool but told us they felt further development of the tool was necessary to ensure staffing levels were sufficient. We saw people had to wait for support and buzzers were not always answered in a timely manner. We found a lack of staff on the nursing floor and had to intervene to support someone who needed support.

On the first day of the inspection there were no indicators, such as people having to wait long a long time in response to activating their call bell, or people being left unsupervised for long periods of time in communal areas, or staffing rushing around, to indicate these staffing levels insufficient to meet people's needs. On the second day of the inspection we saw that people were left unsupervised in one of the communal lounge

areas. When we asked if there should be staff in the lounge one care worker told us, "Yes, there should be someone in here." The staff member remained in the lounge offering support when needed. We discussed this with the operations manager who advised they would speak to staff.

The interim managers confirmed that they currently had three nursing staff vacancies and that this had been the case for some months. They told us that they relied on agency staff to cover these vacancies. We saw the operations manager had increased the nurses on duty to two and had requested a consistent cohort of agency nurses for this.

One relative we spoke with said, 'The biggest problem here is the changeover in staff. The staff don't get to bond with people. Residents used to have a 'named nurse' who looked after them. They don't now. The new carers don't realise she (family member) can't walk very far.' We spoke with the interim managers about the high dependency on agency staff and how this issue was to be addressed. They assured us that they had recently approached two agency nurses who confirmed they would be based in the home in order to provide continuity of care. Agency staff we spoke with confirmed this. They said "I have regular shifts in the home now over the next four to five weeks, which will give them stability and a chance to look at the care plans."

People and relatives we spoke with felt the service was safe. One person told us, "I'm alright in here, it's a nice place." A second person said, "Lovely girls and they know what I need so yes, I'm safe." One relative we spoke with told us, "My [relative] has been here a while now and it's a great home, they are absolutely fine here."

We found the provider ensured appropriate health and safety checks were completed. We found up to date certificates to reflect electrical wiring test and portable appliance tests had been completed.

A business continuity plan was in place to ensure staff had information and guidance in case of an emergency. People had personal emergency evacuation plans in place that were available to staff.

Requires Improvement

Is the service effective?

Our findings

The operations manager provided an up to date training matrix. This confirmed that staff training was not up to date across a range of subjects. For example, food hygiene and moving and handling. This meant we could not be sure that staff had the appropriate knowledge to support people in the service.

People living at Craigielea Nursing Home had specific clinical care needs and we found not all staff received training in these areas. For example, there were people living at the home who had diabetes. We found that the provider had failed to deliver appropriate training to both nursing and care staff in respect of these areas. We deemed this to be a risk as it was important for all staff supporting people to have a baseline knowledge around people's needs. For example, care staff were supporting people without any knowledge of diabetes. This meant they would not be able to identify the signs and symptoms of someone about to have a diabetic incident, therefore they would not be able to mitigate risks to the individuals in a timely manner.

We also found one of the nurses had not received training in care of a percutaneous endoscopic gastrostomy (PEG). A PEG is a tube which is passed into a person's stomach to provide a means of providing nutrition when oral intake is not adequate or possible. The operation's manager told us that the provider was aware of this issue and steps had been taken to ensure the nurse received training. In order to mitigate against this risk the provider had taken the decision to increase the level of nursing staff to two. The additional nurse being provided by an agency with the skills and experience of managing a PEG and people with diabetes.

We reviewed the supervision plan the manager had developed. Staff we spoke with told us they did receive supervision, however we found this was not in a timely manner. We found that the nurses employed at Craigielea Nursing Home had not received clinical supervision. Clinical supervision is important so nursing staff have an opportunity to have their skills observed by a competent practitioner and to discuss the support they may need to fulfil their role. We found that agency staff were not receiving an induction into the home. This meant that agency staff were taking charge of the home without an introduction to Craigielea Nursing Home.

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

We found some work had commenced regarding the training needs of staff. Face to face training for PEG and venepuncture had been planned in on a fortnightly basis for nurses, as well as training to cover all key nursing skills and competencies. Inductions had commenced with the agency nurses who were working in the home. The operations manager told us, "As soon as the clinical lead starts they will be looking at the clinical supervisions for nurses as a priority." We were informed a clinical lead had been appointed as was due to start at the end of October 2017. Following our inspection the operations manager sent us information to confirm that all nursing staff had completed training in PEG and venepuncture.

We observed both permanent and agency nursing staff administer PEG feeds in a safe manner during the inspection. Nursing staff we spoke with had a clear understanding of how to administer and care for people with PEG. Staff explained the need for people to be positioned in a specific way during and after their feed.

The staff we spoke with confirmed they had been provided with training which included moving and handling, first aid and 'challenging behaviour' which was described as "very good."

We found people were offered a varied and nutritious diet and told us they enjoyed their meals. One person told us, "Yes, I like the food here." Another said, "I have no problems with eating, but if I want anything they do it". One relative told us, "Food's good and plenty of it." Where people had nutritional needs these were assessed and plans were in place to support people with their dietary needs. For example, specialised diets. We observed people in the dining areas and saw staff supporting people in a safe manner; people were not rushed and were offered a choice of meal. One care worker told us, "They are given a choice if they don't want it there is always something else." Fluids were readily available throughout the meal. People were supported with drinks and snacks throughout the day.

We found some gaps in recording on people's food and fluid charts. One person's food and fluid intake charts were not completed consistently, we found significant gaps in two days' worth of records. We raised this with the operations manager as a concern as the recording of people's intake formed a part of their nutritional risk assessment. The operations manager told us, "These are now being checked daily." The review of food and fluid charts was highlighted on the provider's action plan with the charts being sent to the manager office daily. On the third day of our inspection we reviewed the action plan which advised these were improving.

We saw staff to be attentive, offering people the support they needed. Care staff provided people with choices and ensured the food was offered at a pace that was comfortable for them. Dining tables were attractively presented, for example with table clothes and condiments, and there was a relaxed and sociable atmosphere.

People's healthcare needs were not always monitored effectively. For example, in one person's care notes we saw that they had sustained a fall on the 10 September 2017, yet the evaluation of this person's care plan on 15 September 2017 stated 'no falls this month.' There was also no evidence of medical intervention being sought for this person who had sustained unexplained bruising and bleeding during another incident. This was raised with the operations manager at the time of the inspection so they could investigate.

We found records in some people's file to demonstrate they had contact with health care professionals. For example, speech and language, tissue viability and GP's.

The Mental Capacity Act 2005 (MCA) providers a legal framework for making particular decisions on behalf of people who 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 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 MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff we spoke with understood the principles of the MCA and DoLS and that consent to care and support

was important. One care worker told us, "If they have a DoLS it is written into their care plan." Another told us, "We have to act in the person's best interests."

We found the provider did not have a robust system of monitoring the timeliness of people's applications for renewal of Deprivation of Liberty safeguards (DoLS). During the inspection we found the operations manager had made the appropriate applications to the local authority. During the inspection we found no evidence that people were being deprived of their liberty.

We saw attention had been given to the physical environment where people with dementia were accommodated which reflected good practice, for example, toilet seats and grab rails in en-suite shower rooms were a bright contrasting colour so that they could be easily seen. The lighting in these areas was also very good and would assist people with visual difficulties to see. However, the corridors were all a similar colour and some led to a dead end. Other than people's names written on a piece of A4 paper and stuck on their bedroom door there were no other adaptations made to the environment, for example a picture or memory box, to help people find their personal space.

Craigielea Nursing Home was spacious with ample space for people who used wheelchairs or mobility aids. Communal areas were set out with easy chairs, televisions and, or radios were available for people to watch/listen to. We saw service users had access to a safe enclosed large garden equipped with bird tables and feeders, garden seats and raised plant beds.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us staff were kind and caring. People gave us positive views when we asked them about the care provided in the service. One person told us, "They are lovely girls." Another said, "We are looked after, her [name of carer] is lovely." A third told us, "You won't get a better place, the foods lovely." One relative told us, "This is a good home, I can't fault them." Another said, "That one [care worker] always has time for a chat and always has a smile. Staff told us they enjoyed working at Craigielea. One care worker told us, "I love working here, to care for them. I wouldn't be here if I didn't enjoy my work."

We found the language used in the care records did not always promote the dignity of people living with dementia. For example, in one care plan a person's behaviour was described as 'attention seeking'. This does not promote a positive image or understanding of the person with dementia or reflect a person centred approach to care. We found the provider had organised dementia training for staff to be completed by the end of October.

Care workers supported people to meet their choices and preferences. People were supported to be as independent as possible. Care workers said they encouraged people to do as much for themselves as possible. For example, eating meals or getting washed and dressed.

We observed care workers showed kindness throughout their interactions with people showing genuine relationships. They were friendly and caring in their conversations with people, crouching down to maintain eye contact, using gestures, facial expressions and touch to communicate. When communicating with people we saw staff waited patiently for people to respond. Staff clearly explained options which were available to the person and encouraged them to make their own decisions. For example, whether they wished to join in activities or have a drink and snack.

Although we saw people were supported and cared for by care workers who knew their needs well. We found a lack of continuity of nursing staff within Craigielea Nursing Home. This was being addressed by the provider's Human Resources manager who told us that recruitment of nurses was a priority. The hand over sheet where people's care and support needs were summarised had been enhanced to capture more information about people's health needs.

We observed people were treated with dignity and respect. Care workers told us they ensured people had privacy when receiving care. For example, keeping doors and curtains closed when providing personal care, explaining what was happening and gaining consent before helping them. We observed staff support people with their mobility needs in a dignified way when using equipment to move and assist.

We saw one person become upset and anxious, staff understood the best way to support them at this time providing them with reassurance, warmth and understanding. We observed staff have a laugh and a joke with people who by the very nature of their responses enjoyed the interaction.

We joined people in the dining room at lunch. We observed staff treating people with dignity. People were

asked if they wanted to have protection for their clothes during lunch and were supported with napkins or protective aprons. We observed staff demonstrating respect for people by asking what they preferred for lunch, offering choices and alternatives. Staff supported people to eat and drink in a pace appropriate to their needs which ensured people were support to be as independent as they could be. Time was taken when supporting people to eat by ensuring they had finished one mouthful before being given another. Meals were not rushed. Staff were encouraging prompting people to 'eat a little bit more'.

We found several compliment and thank you cards had been sent to the home. Comments included, "A big thank you to you all the nursing staff and carers who took such good care of [name]" and "Thank you for all the care, consideration and all the extra miles gone." We also found positives comments from health care professionals and students. For example, "A very nice home" and "Thank you for all the staff so much for helping and supporting me."

People's rooms were comfortable, some with pieces of their own furniture and items which were personal to them and each room reflected the person's interests and character. We saw people had items close by when in the communal areas such as spectacles, tissues and hand held devices such as and iPad.

Information was readily available to people, relatives and visitors about independent advocacy.

Although we found aspects of the service to be caring we are not able to give a rating of good as the provider was not supporting the service to deliver caring outcomes for people.

Requires Improvement

Is the service responsive?

Our findings

We found not all people's care plans were personalised. Details of people's current needs were not always reflected within the care plan. For example, one person's breathing care plan did not mention the risk associated with PEG feeding and the risk of pulmonary aspiration. Aspiration is when food is inhaled, stomach acid, or saliva into your lungs. People's fluid requirements were not recorded in hydration and nutritional care plans.

Due to the recent concerns raised by the local authority the provider had developed an action plan to drive improvement in the home. We found the operations manager had tasked a nurse from another of the provider's locations to re-assess and reviews care plans of the most complex people. Another of the permanent nurses had been given some supernumerary time to also re-assess and review care plans. We saw some care plans had been re-written, these were more personalised. The operations manager told us, "I will be monitoring these and checking the quality."

We discussed people's care needs with staff to ensure care was being provided in a person centred way. Staff were able to tell us how they supported people. Such as, how people's personal hygiene needs were met in a way the person preferred, examples also included, how people's health needs were supported by contacting GP's and community nurses, where people required positional changes or additional welfare checks.

We spoke with agency nurses to find out how they were made aware of people's needs. One nurse told us, "We get a detailed handover and have access to information about their needs, we also have senior carers to work alongside. If there is any query then I would speak to the manager." Another told us, "We work with the senior carers as well as having details on the handover." We observed agency staff supporting people with complex needs such as PEG feeds and the administration of medicines to people with PEG making sure the person was seated in an appropriate position in line with their care plan.

The care records did not demonstrate a person centred approach to planning activities. For example, in one person's personal history profile it stated that they previously enjoyed sewing. However, we saw in the activities plan for this person, there was no information about their previous lifestyle, hobbies or interests. This could place people at risk of social isolation.

There was an activities co-ordinator and during the inspection she was spending time showing people photographs taken of a recent visit by a 'pat pony.' During the inspection we saw different activities going on with people, for example, art and crafts and a coffee morning. The activity coordinator had organised an outside retailer to visit the home so people could do some shopping. However in the communal area where the majority of the people requiring nursing care were seated we found that although people appeared settled, we found little meaningful engagement.

We recommend the provider reviews their approach to person centred care planning to acknowledge activity opportunities for people by referring to: National Institute of Clinical Excellence (NICE) guidelines:

Mental Well-being of older people in care homes, published in December 2013.

Staff felt the service was responsive to people's needs. One senior carer told us, "I know when people need to be seen by the GP or nurse. I am able to do observations such as oxygen levels, temperatures that type of thing." They went on to explain what action they would take if a person demonstrated symptoms of a urine infection and discussed the symptoms of sepsis and that they would take action such as ringing for emergency support.

Staff told us they were kept up to date about people's needs through handovers and were aware of people's needs. We found the provider had improved the quality of information on the handover sheets. One care worker told us, "We get a detailed handover, it means you get background of what's happened if you've been off for a couple of days." Another told us, "We always get to know if there are any changes, the handover is good."

The provider had a policy and procedure in place for complaints which was accessible to people and relatives. The manager kept a file containing complaints. However we saw when complaints had been raised a record was kept, together with the action taken to address the concern. However, other than on one occasion, there was no evidence that complainants had been notified of the outcome of their complaint. This was not in keeping with the Provider's own policy. People told us they knew how to complain. "One person told us, "I would tell the head one." Another told us, "The manager, but I have no complaints."

We recommend that the provider seeks advice and guidance from a reputable source, about the management of, and learning from complaints.

We examined the care records for one person. We saw it had been recorded in the person's daily notes that, as a result of their dementia, they regularly became agitated. We found that a referral had been appropriately made to mental health professionals. Staff were currently monitoring this person's behaviour to identify possible triggers in order for staff to support this person in a positive way and help to avoid the behaviour. This demonstrated the service had responded positively to this person needs.

We found the manager held staff, resident and relative meetings to disseminate information. Relatives told us they where they were able to express their views during such meetings. However, they recently described a change to the mealtime arrangements and said that they had not been consulted about this. They said, "They now get a lighter meal at lunchtime and a main meal at night time. It used to be the other way around. It means my mam is going to bed on a full stomach." We saw the operations manager had arranged a relatives meeting for 5 October to introduce herself and to discuss any issues or concerns.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we identified a repeated breach of regulation 17, good governance. The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service provided.

At this inspection we found the provider's quality assurance systems and processes did not capture shortfalls in systems and practices at the home. These shortfalls have contributed to three continuing breaches of regulation, in addition to newly identified breaches of regulation at this inspection.

The provider's training plan did not include specific areas of training necessary for staff to provide safe care and treatment to the people living at Craigielea Nursing Home. Nurse's clinical skills were not properly assessed for levels of competence. No records were available to demonstrate that nurses were receiving any form of clinical supervision or guidance.

Care plan audits lacked detail and in some cases there were no target dates for the completion of actions. Not all the audit records were signed and dated. Audits had not identified the lack of recording in people's food and fluid intake charts or the lack of consistent recording within people's risk assessments.

We found risks were not being managed. For example, the provider's safeguarding processes had failed to identify potential safeguarding concerns leaving people at risk. Potential safeguarding incidents were not always reported. Where the local authority safeguarding team had identified risks to people's safety and welfare there was no evidence that these risks were being managed.

We saw that monthly infection control audits were carried out. In July and August 2017 it had been identified that there was an unpleasant smell. We found this unpleasant smell remained on the day of the inspection. This demonstrated that the internal auditing processes were ineffective.

Complaints were not always managed appropriately. The manager did not always inform the complainant with an outcome of their complaint.

Supervision records showed some supervision had taken place but not at the frequency stated on the provider's planner.

We found issues with record keeping. Staff used a file kept in the lounge area which held several documents pertaining to people's care needs. The file contained documents named which staff completed on a daily basis. We found these were task focused with boxes to tick if someone had had a bath, shower, creams applied. This meant the provider was using an inappropriate method of recording people's personal support needs. Food and fluid charts were in place for people who required their intake monitoring, we found these were not totalled or reviewed to ascertain if the person had sufficient intake and hydration. Positional charts were not always completed to demonstrate people had received appropriate pressure relief. The process of monitoring nutritional intake was not robust in that we found no oversight from senior

carers or nursing staff. People's personal care records were not stored securely. Handover sheets containing detailed personal information about people needs were left on a table accessible to people, relatives or visitors.

We spoke with the manager about their role in the home and to ascertain what support they had received since being employed. They advised they had not received a full induction and had not been offered a mentor to support them. No periodic review of their position as manager had been undertaken.

We found the last provider visit to monitoring quality was April 2017. The report dated 25 April 2017 detailed action needed to be taken to achieve compliance. We found no evidence these actions had been addressed.

These findings demonstrate a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

During the inspection we found a potential safeguarding incident in one person's care records. We reviewed the provider's safeguarding file and found no record of this incident or evidence that a notification had been submitted to CQC. We brought this to the attention of the operations manager who submitted a notification to CQC regarding the incident we had found. This meant that the provider had failed to submit a statutory notification to the Commission in line with legal requirements. We are dealing with this matter outside of the inspection process.

This is a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

On the first day of the inspection we met the newly appointed operations manager. The manager was on annual leave and in light of concerns raised by the local authority, the provider had two managers from other services overseeing Craigielea Nursing Home until the manager returned. The provider told us, "[Operations manager] will be staying in Craigielea Nursing Home to work with [manager]." The operations manager is an experienced manager and had a history of supporting homes to improve.

We found a robust action plan had been developed to address the concerns raised by the local authority. The operations manager had also added additional areas following their review of the home. The plan set out the person responsible for the action required, a date for completion and a weekly update section. The operations manager told us, "The plan has been shared with the local authority and they are happy with it." We reviewed the plan and found it covered all the areas we had highlighted. Some work had already been achieved in terms of developing and implementing systems and processes.

People and relatives felt the service was well managed and spoke highly of the manager and the staff. Comments included, '[Manager] is really nice, she is always friendly' and '[Manager] is approachable, they all are [staff].

Staff felt the manager was approachable. One care worker told us, "[Manager] is supportive and approachable, we all get along" Another care worker told us, "We have better support now, things are getting put right."

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safe and proper management of medicines. Regulation 12 (2) (g) The provider had not assessed the risks to the health and safety of service users receiving care and treatment. Regulation 12 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to have systems and processes in place to identify potential abuse and take preventative actions, including escalation where appropriate. Regulation 13 (2)

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 The provider had not ensured systems and processes were operated effectively to assess, monitor and improve the quality of the services provided. Regulation 17 (2) (a)

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

The provider had failed to ensure staff received appropriate support, training, professional development, supervision as is necessary enable them to carry out duties they are employed to perform.
Regulation 18 (2) (a)