North East Care Homes Limited

Woodlands

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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 28 June 2016 and was unannounced. This meant that the provider and staff did not know that we would be visiting. A second announced visit was carried out on 29 June 2016 to complete the inspection.

We carried out a comprehension inspection in May 2015 where we found four breaches of the regulations. These included meeting nutritional and hydration needs; staffing; premises and equipment and good governance.

After the comprehensive inspection, the provider wrote to us on 11 September 2015 to say what action they were taking to meet legal requirements.

We inspected the service again on 28 and 29 June 2016 to check that action had been taken. We found that improvements had been made with regards to staffing and meeting nutritional and hydration needs. However, we identified serious shortfalls with the safety of the premises.

Woodlands provides care to a maximum of 42 older people, some of whom have a dementia related condition. There were 27 people living at the home at the time of the inspection.

A stairgate had been fitted to the main stairwell. This was neither secure nor fit for purpose. The fitting of some window restrictors in the home did not conform to the Health and Safety Executive (HSE) guidelines to prevent any serious accidents or incidents. Some of the flooring was uneven and concerns had been raised about a number of fire doors. The kitchen freezer had a crack in the bottom and was an electrical safety risk and a gas safety check had highlighted that the secondary boiler was not safe to use. One person with a dementia related condition had left the home unobserved on several occasions, placing them at risk of harm. Although some measures had been implemented such as bolts on the front door and key pads; the manager said that they were still waiting for anti-tamper locks to be fitted to the fire exits, since this person could override the key pads by pressing the emergency exit buttons. Some of the décor and furnishings were worn and damaged. Five of the lounge chairs had damaged cushion covers. The lounge/dining area carpet was stained and was covered with ingrained food and debris and the first floor carpet was threadbare in places. The chairs and carpets not only looked unsightly, but were an infection control risk because they could not be cleaned easily. Further work was required to ensure that the environment met the needs of people who had a dementia related condition.

There were deficits in the governance of the service since action to address the premises shortfalls was not taken in a timely manner.

Following our inspection, the regional manager emailed us to state that immediate action had been taken to ensure the safety of the premises. Whilst we acknowledged the work which had been carried out; we considered that action should have been taken in a timely manner and not, as it appeared, in response to

our intervention.

There was a registered manager in post. A registered manager is a person who has registered with the 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 and associated Regulations about how the service is run.

Staff told us that the service had been through a period of uncertainty. They told us that there had been changes in the provider's management structure. Although the provider's legal entity remained the same - 'North East Care Homes Limited,' a new management company was now overseeing the service; this had been the second management company within 12 months. Staff told us that these changes had affected morale.

There were safeguarding procedures in place. Staff knew what action to take if abuse was suspected. They were fully aware of the whistle blowing procedure.
Safe recruitment procedures were followed. No concerns about staffing levels were raised by people or relatives. We observed that staff carried out their duties in a calm unhurried manner.

The manager provided us with information which showed that staff had completed training in safe working practices. However, with the exception of dementia care, most staff had not carried out training to meet the specific needs of people including; falls awareness, continence awareness, Parkinson's disease and pressure area care. The manager informed us that she was in the process of organising specific training.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions 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. The manager had submitted DoLS applications to the local authority to authorise in line with legal requirements. Although staff were following the principles of the MCA, improvements were required to ensure that evidence was available to demonstrate this. We have made a recommendation that the provider ensures that there is documented evidence that care is always sought in line with the Mental Capacity Act 2005.

At our last inspection, the provider had used an external catering company to provide meals at the service. At this inspection, the provider no longer used the catering company and employed their own kitchen staff. People and staff explained that this had improved the meals at the service.

Staff who worked at the home were knowledgeable about people's needs. We observed positive interactions between people and staff. People were supported with kindness and care. We noted however that some people with a dementia related condition were not wearing footwear. We considered that this not only affected people's dignity, but also their safety. The manager told us that this had been addressed immediately.

Person-centred care plans were in place which gave staff information about how people's needs were to be met.

There was an activities coordinator employed to help meet the social needs of people. The activities coordinator had been off for a period of time and had only recently returned to the service. We saw that she sat with people and talked with them in the morning and organised group activities in the afternoon.

There was a complaints procedure in place. Three complaints had been received and we noted that these had been responded to in line with the provider's complaints procedure. Meetings and surveys were carried out.

The overall rating for this service is 'Requires improvement.' However, we are placing the service in 'special measures.' We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment, staffing and good governance. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 safe.

We identified serious shortfalls with the safety, suitability and security of the premises and equipment.

Following our inspection, the regional manager emailed us to state that immediate action had been taken to ensure the safety of the premises.

There were sufficient staff to meet people's needs and safe recruitment procedures were followed. There were safeguarding procedures in place. Staff knew what action to take if abuse was suspected.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Staff had carried out training in safe working practices. We noted however, that most staff had not carried out training to meet the specific needs of people who lived there with the exception of dementia care training.

Further work was required to ensure that the environment fully met the needs of people with a dementia related condition. Staff were following the principles of the MCA, although improvements were required to ensure that evidence was available to demonstrate this.

People's nutritional needs were met and they were supported to access health and social care professionals.

Is the service caring?

Good

The service was caring.

People and relatives told us that staff were caring. We saw positive interactions between people and staff.

People and relatives told us staff promoted people's privacy and dignity. Some people with a dementia related condition were not

wearing footwear which we considered did not promote their dignity or safety.

People and relatives told us, and records confirmed that they were involved in people's care and regular reviews were carried out.

Is the service responsive?

Good

The service was responsive.

Care plans were in place which detailed the individual care and support to be provided to people.

An activities coordinator was employed to help meet people's social needs.

There was a complaints procedure in place. Feedback systems were in place to obtain people's views. Meetings were held and surveys carried out.

Is the service well-led?

Inadequate

The service was not well led.

There were deficits in the governance of the service since action to address the premises shortfalls had not been taken in a timely manner.

Staff told us that the service had been through a period of uncertainty with two changes of management company overseeing the home. Staff told us that these changes had affected morale.

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Detailed findings

Background to this inspection

The inspection took place on 28 June 2016 and was unannounced. This meant that the provider and staff did not know we would be visiting. A second announced visit was carried out on 29 June 2016 to complete the inspection. The inspection was carried out by an inspector.

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.

Most of the people who used the service had a dementia related condition which meant they were unable to communicate their views verbally. We therefore observed staff practices and spoke with their relatives in order to determine how their care was delivered.

We spoke with six people and two relatives on the days of our inspection. We contacted 12 relatives following our inspection by phone and managed to speak with six of them to obtain their views of the service. We conferred with a reviewing officer and a community nurse from the local NHS Trust and a social worker. We also spoke with a pharmacist and a care home support technician from the Medicines Optimisation team and a private chiropodist. We also consulted a contracts officer from the local authority.

We spoke with the nominated individual and regional manager from the new management company who were overseeing the running of the service, the registered manager, three senior care workers, two care workers, the admin/laundry assistant, the cook and a member of the domestic team. We examined four people's care records. We also viewed two staff files, to check details of their recruitment and checked 32 staff training records. We looked at a variety of records which related to the management of the service, such as audits, minutes of meetings and surveys.

Prior to carrying out the inspection, we reviewed all the information we held about the home. We did not request a provider information return (PIR) prior to our inspection. A PIR is a form which asks the provider to give some key information about their service, how it is addressing the five questions and what improvements they plan to make.

Following our inspection, we passed our concerns regarding the premises to Tyne and Wear Fire and Rescue Service, the local authority's environmental health service and contracts and commissioning team.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we identified two breaches relating to staffing and premises and equipment. We found that certain areas of the home were in need of redecoration and some of the furniture looked worn and had an odour. Concerns were raised about an open stairwell which was considered a falls risk. In addition there were not sufficient numbers of staff deployed to ensure the safety and well-being of people who lived at the home.

At this inspection in June 2016, we found serious shortfalls in the safety of the premises. A wooden stairgate had been fitted to the main stairwell. The stairgate was not locked, because it was not yet linked to the fire alarm system to ensure that it would open automatically if the fire alarm was activated. We read the minutes from a health and safety meeting which was held in May 2016. These stated, "[Name of staff member] identified the stairwell gate which the residents keep leaning on swings open which has been ongoing for a long time now. [Name of manager] states head office and [name of management company] are both aware of this and it is a priority."

We noted that the bannister was loose and not secure at the bottom of the stairs. The manager told us that this was due to the weight of the stairgate which had been fitted. This was a health and safety risk since the bannister could give way or collapse if someone were to fall or lean against it.

In September 2015, one person had left the home from a ground floor bathroom window into the enclosed court yard. We noticed that no action had been taken to limit the opening of this window to prevent any further incidents and protect the safety of people who lived at the home. In addition, the fitting of some window restrictors in the home did not conform to the Health and Safety Executive (HSE) guidelines because they opened wider than10cm. Serious injuries and fatalities have occurred when people have fallen from or through windows in health and social care premises.

Some of the flooring throughout the home was uneven. The manager told us this was a "trip hazard." This was confirmed by some of the staff with whom we spoke. We read the minutes from a recent "relatives' and residents' meeting." These stated, "[Name of manager] stated there is a dip in the floor near the sluice caused by decaying plaster underneath due to heat from the pipes."

Fire door closures had been fitted to bedroom doors. The manager told us that this had resulted in many of the door hinges dropping which affected the structure of the doors and door frames because of the extra weight involved. Two bedroom doors were very difficult to open and close and we noted that one door frame was damaged and cracked. The maintenance man carried out weekly fire door checks. He identified deficits with 32 of the bedroom doors. We spoke with the manager about this issue. She told us, "[Name of door company] came out…It's not a straight forward job. We are discussing this on Friday." This meant there was a risk in relation to fire safety and the structural safety of doors and frames.

We looked at recent catering audits and noted that there was a crack in the bottom of the freezer. When staff defrosted the freezer, water would pool at the bottom of the freezer which was an electrical safety issue.

Checks and tests had been carried out on certain aspects of the premises including electrical and gas safety. We noted at the last gas safety check in January 2016, the gas engineer had issued a warning notice in relation to the secondary boiler which they had indicated was not safe to use. The manager told us that they no longer used this boiler. We read the minutes of the health and safety meeting which was held in March 2016. These stated, "[Name of manager] asked why is there a fluctuation in water temperatures at present. [Name of staff member] said that it might be due to working off one boiler." We checked recorded water temperatures and these ranged from 33.5 – 43.3 degrees Celsius. We spoke with the manager about this issue. She told us, "The whole system is ready for a full clear out. There is sludge in the radiators. The plumber is coming out in August to drain the radiators and look at the boiler."

We examined the minutes of a health and safety meeting which was held in March 2016. A member of staff had raised concerns about the possible presence of asbestos in one of the bedrooms. We spoke with the manager about this issue, she told us, "There has been no assessment carried out. [Name of provider] states he was here when the building was built and he says there is no asbestos. It's been built for about 25 years." It is a legal requirement for providers to undertake an asbestos survey since asbestos containing materials, if found, can pose a health risk.

We checked security at the home. The manager told us that one person who had a dementia related condition had left the home unobserved on several occasions, placing them at risk of harm. Although some measures had been implemented, such as bolts on the front door and key pads, the manager said that they were still waiting for anti-tamper locks to be fitted to fire exits since this person could press the emergency exit buttons which overrode the key pads.

We checked equipment at the home. We noticed that two people had fallen and staff were not initially aware as the batteries in their sensor mats had not been working. These mats alert staff when someone is moving around their room unsupervised, for example during the night, when they may be at an increased risk of falling. We spoke with the manager about this issue. She told us all of the sensor mats except for one were now mains operated. Following our inspection, the regional manager contacted us and told us that daily documented checks were carried out on each sensor mat to ensure they were fully operational.

We noticed that some of the décor and furnishings were worn and damaged. Five of the lounge chairs had damaged cushion covers. The lounge/dining area carpet was stained and covered with ingrained food and debris and the first floor carpet was threadbare in places. There were areas of damaged paint work throughout the home. The chairs, carpets and damaged paintwork not only looked unsightly, but were an infection control risk because they could not be cleaned easily.

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

We requested that the provider take immediate action to ensure people's safety. Following our inspection, the regional manager emailed us to state that all windows were now fitted with appropriate restrictors, the stairgate was now in a fixed position, all fire doors now closed, a new freezer had been purchased and a plumber was visiting the home to assess the secondary boiler. Whilst we acknowledged the work which had been carried out; we considered that action should have been taken in a timely manner and not, as it appeared, in response to our intervention.

Individual assessments were in place where people had been identified as being at risk. They described the actions staff were to take to reduce the possibility of harm. Areas of risk included falls, moving and handling, malnutrition and pressure ulcers. We noted that these had been reviewed and evaluated regularly.

At our last inspection we identified a breach with staffing levels. At this inspection, seven out of eight relatives, all people with whom we spoke and staff raised no concerns about staffing levels. One relative said, "There is always someone around keeping an eye on them and making sure they are safe. Obviously in all care sectors there needs to be more staff." Another relative stated that she thought that more staff should be on duty from 8pm onwards when staff were busy assisting with supper, administering medicines and supporting people to go to bed.

Staff told us that although there were no more staff on duty, the number and dependency of people who lived at the home had decreased. We observed that staff carried out their duties in a calm unhurried manner and a member of staff was present in the lounge area throughout the day, to ensure people's safety. We saw that staff monitored people discreetly. They sat and talked with people individually and joined in with communal conversations.

Staff told us, and records confirmed that correct recruitment procedures were carried out before they started work. We saw that Disclosure and Barring Service (DBS) checks had been obtained. A DBS check is a report which details any offences which may prevent the person from working with vulnerable people. They help providers make safer recruitment decisions. Two or three written references had also been received. The manager completed a written interview assessment. She checked and documented how prospective staff communicated and interacted with people. We read one staff member's interview record which stated, "Met with [name of person] at front door – good communication. Very positive even though [name of person] is unable to communicate due to her word finding difficulties and sequencing." The manager told us, "It's important to check [communication] because you can see how they [prospective staff] are going to interact with the residents when they are here. It's no good employing someone if they're going to shy away from the residents or don't feel comfortable communicating with them."

People told us that they felt safe. One person said, "I feel safe here, I can't expect my family to look after me when they are at work and they know that I am safe here." This was confirmed by relatives. One relative said, "I have peace of mind knowing that she is there. She looks on Woodlands as her home." There were safeguarding policies and procedures in place. Staff had completed safeguarding training and were knowledgeable about what action they would take if abuse was suspected. They told us that they could contact the manager with any concerns they had.

There was a system in place to manage people's finances. We found that the management of one person's finances did not fully protect them from the risk of financial abuse. Following our inspection, the manager told us that this had been addressed immediately.

We checked the management of medicines and found that medicines were managed safely. We spoke with a pharmacist and pharmacy technician from the Medicines Optimisation team who were visiting the home. The pharmacist told us, "Everything we have suggested they have done" and "They are managing Warfarin [blood thinning medicine] perfectly well and following procedures." The pharmacy technician said, "We've been fantastically well received, they are really receptive."
We looked at medicines administration records and noted that these were completed accurately and saw there was a system in place for the safe receipt, storage, administration and disposal of medicines.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we identified a breach relating to meeting people's nutritional and hydration needs. We also found concerns with training and there was a lack of documented evidence to demonstrate that care and treatment was sought in line with the Mental Capacity Act 2005. In addition, the design and decoration of the premises did not fully meet the needs of people who lived with dementia at the time of the inspection.

At this inspection in June 2016, we found that improvements had been made regarding meeting people's nutritional and hydration needs, although further improvements were still required regarding the environment, training and evidencing the MCA.

People and relatives told us that they considered that the service effectively met people's needs. One person said, "They know what they are doing." Another person said, "Most are well trained, they go to training sessions to bring them up to date." The chiropodist said, "Everyone seems to know what their role is. The carers know what to do"

Staff told us that there was sufficient training available. We looked at the training records for 32 staff. We noticed that they had carried out training in safe working practices, for example, practical training had now been carried out in areas such as moving and handling and first aid. With the exception of dementia care training; we noted however, that most of the staff had not carried out training to meet the specific needs of people who used the service such as; diabetes awareness , activities provision and Parkinson's Disease. Several staff told us that training to meet people's specific needs would be beneficial. Some individuals were incontinent and others were at risk of pressure ulcers. We saw that only two staff had completed continence awareness training and one staff member had undertaken pressure area care training. Due to people's physical and mental health needs, many were at risk of falling. We noted that only five staff had completed falls awareness training. We saw that four people who had a dementia related condition were not wearing any footwear to help reduce the risk of falls. We spoke with the manager about this issue. She told us she was in the process of sourcing training to meet the specific needs of people who lived there.

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

Staff told us, and records confirmed that they undertook induction training when they first started working at the home. This meant that staff felt prepared when they started working independently at the home and supported the effective delivery of care.

Staff informed us they felt supported by the manager. One staff member said, "No one could ever criticise [name of manager]. She is so supportive." Regular supervision sessions were carried out and staff had an annual appraisal. One staff member said, "I have supervision all the time, there is always something to discuss." Supervision and appraisals are used to review staff performance and identify any training or support requirements.

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that the manager had submitted DoLS applications to the local authority to authorise in line with legal requirements.

We found that improvements had been made with regards to evidencing decisions relating to the MCA. Mental capacity assessments were now mostly decision specific and had been completed for areas of care such as covert [hidden] medicines administration and finances. We noted that MCA assessments were not in place for the use of sensor mats to demonstrate that staff had assessed and considered whether the use of sensor alarms were in people's best interests and were the least restrictive option. Following our inspection, the manager told us that these were now in place.

We noted that relatives had signed consent forms such as consent to treatment forms and sharing information. It was not clear however, whether people's relatives or representatives had been appointed as a lasting power of attorney (LPA). LPA is a legal tool which allows people to appoint someone (known as an attorney) to make decisions on their behalf if they reach a point where they are no longer able to make specific decisions. There are two types of LPA; property and financial affairs and health and welfare. The manager told us that although she checked whether a LPA was in place, she was unsure whether the LPA related to property and financial affairs or health and welfare. This meant evidence was not available to confirm what type of LPA was held to ensure the correct attorney was involved in the correct decisions. Following our inspection, the manager told us, "[Name of administrator] has drafted a letter about this [LPA] and sent it to all relatives."

We recommend that records evidence that care and treatment is always sought in line with the Mental Capacity Act 2005.

At our previous inspection the provider used a contract caterer who supplied all of the home's kitchen staff. At this inspection, the provider employed their own kitchen staff. Staff informed us that meal times had improved. One staff member said, "I did have concerns about meal times, but since [name of cook] has been in the meals are nicely presented and there's a lot more nutritional value now to the meals." People were generally complimentary about the quality of meals now served. Comments included, "The food is better now," "The food is lovely" and "Most of the times it is good, but it can be a bit hit and miss." A relative said, "From what I've seen the food looks lovely." Another relative said, "They involve them and ask them what they want for their meals. Everything looks nice, it's better now [name of cook] is there."

We spent time with people over the lunch and tea time periods on both days of our inspection. Soft classical music was playing and we saw that staff supported people with their meals in a calm unhurried manner and were attentive to their needs. Staff showed people both meal choices. One care worker said, "Look, this is the fishcakes and this is the potato and ham bake - what do you fancy?" This meant they could see and smell the food which was particularly beneficial to people who had a dementia related condition. We heard staff ask people throughout the meals, "Are you alright?" "[Name of person] do you want to try and eat a little more?" "Would you like a drink?" "Did you enjoy what you had?" and "Would you like a hand?"

Meals and drinks were available throughout the day. At 2pm one person asked a member of the kitchen staff for a sandwich. The member of kitchen staff said, "No problem – are you still hungry?" At 7pm, we saw a staff member ask people if they would like a drink of juice or a hot drink. A "hydration and nutrition station" was located in the lounge. The manager told us, "It is basically for residents who want to access fluids and snacks at any time. Some residents are always on the go and burn off a lot of calories, it's easily in sight and people can help themselves." This meant that snacks and drinks were available at any time if people wanted to ensure their nutrition and hydration needs were met.

The cook was knowledgeable about people's needs. She told us, and our own observations confirmed that fortified homemade milk shakes were provided. The cook explained, "I use ice cream, fortified milk powder, fresh fruit, cream and full fat milk…I also do high protein bars for people who walk a lot, made out of peanut butter and whey powder." She told us that one person was on a weight reducing diet and she bought in salmon and low fat sausages.

People's nutritional needs and preferences were recorded in their care plans. We read that one person was allergic to onions and another person was "not a big fan of pasta." We spoke with the cook who told us that she received information about people's likes and dislikes and any special diets people required. This meant there was good communication between care and catering staff to support people's nutritional well-being.

We noted that people were supported to access healthcare services. This was confirmed by people and relatives. One relative said, "When she is feeling bad, they always get the doctor out for her and keep me informed." We read that people attended appointments with their GP, consultants, dentists, opticians and chiropodists. We spoke with a private chiropodist. She told us. "I don't have any concerns about the care of anyone." We also spoke with a community nurse who told us that staff contacted her if there were any concerns about people's healthcare.

We checked the suitability of the design and décor of the service to meet the needs of people who lived there. Pictures and photographs of local scenes and movie stars such as Rock Hudson were displayed on the corridor walls. Staff told us that one person used to be a lorry driver. Staff had put a picture of a lorry on the person's bedroom door to help orientate the person to their room. The manager told us that further work was still required to ensure that the environment fully met the needs of those who had a dementia related condition.

Some health and social care professionals commented on the entrance of the home and felt that improvements could be made. One stated, "It could be more welcoming." Another said, "It's difficult to see anyone when you first come in." Although the administrator's office was located in the entrance of the service, the administrator only worked 13 hours a week and the manager's office was not immediately visible. One person commented on the lighting in the reception area and said, "It's not very light in here, it's a bit dark, it needs cheering up and a brighter light." A third health and social care professional said, "The first thing you see is that thing [stairgate] it doesn't look attractive." The stairgate consisted of a wooden gate with a large oval topped piece of ply wood attached to the back of the gate.

There was an enclosed courtyard which people could access. We noted however, that this area looked unkempt. The manager told us that the staff who usually "spruced up" the courtyard area had been off on extended leave.

Good

Is the service caring?

Our findings

People and relatives were complimentary about the caring nature of staff. Comments from people included, "It's my home. I've been here 10 years. The staff are very nice and are all very happy and helpful. Not one of them is a bit grumpy – they are always laughing," "It's a very nice home and the carers are lovely," "The staff are all very nice. I don't find any of them not nice" and "The caring is excellent." Comments from relatives included, "They know our names, they are all very caring. They interact with the residents well," "The environment needs some TLC, but it's the atmosphere and the care which is important to us," "The staff are so lovely, caring and helpful" and "They are very caring."

Health and social care professionals were also positive about the caring nature of staff. The reviewing officer told us, "They know the residents; they don't look blank when you ask them about the residents" and "The care is there." A community nurse said, "The carers are lovely. They are very good" and "The carers care." The chiropodist said, "I don't have concerns about the care of anyone…The staff are super." A social worker who had been carrying out one person's care review informed us, "The carers do care. I have been sitting here for a while and heard staff being lovely with them, joshing and joking with them. From what I've seen it's caring. The family have been perfectly happy with the care." This was confirmed by the people's relatives.

We observed positive interactions between people and staff. We saw staff chatting with individuals on a one to one basis. One staff member told us, "The most important thing we can do is talk to them." Staff displayed warmth when interacting with some people whose behaviour could be described as challenging. Staff were tactile in a well-controlled and non-threatening manner. One person kept shouting out, "I need help." We saw a staff member kneel down beside them and take their hand and say, "I'm here, what do you need help with?" We heard one person say to a member of staff, "You are a lovely lady to me;" the staff member replied, "and you are a lovely gentleman to me." One person became anxious when staff used a hoist to move them from an armchair to a wheelchair. "Will you watch me?" the person asked staff. A staff member reassured them and said, "We are here [name of person], you're okay. We will be very careful." We observed one person looking after a doll which appeared to give them comfort. A member of staff said, "They love the doll, they respond well to that and they have teddies in their room. They like something to hold to give them comfort."

We noticed positive interactions, not only between care workers and people, but also other members of the staff team, such as domestic and kitchen staff. We heard one of the domestic staff say, "[Name of person] your hair is looking lovely, have you just had it done?" The cook and kitchen assistant spent time communicating with people and it was evident that people appreciated their interactions.

There was a keyworker system in place. Staff told us that this helped them identify with people and build up a rapport with them. One member of staff said, "Keyworkers make sure that people's care plans are up to date and if they want any personal letters written and make sure their rooms are nice and they have all their toiletries. It's just nice to be able to put yourself out for that person."

We observed care staff assisted people when required and care interventions were discreet when they

needed to be. During meal times staff carefully supported people to wipe their mouths and hands to ensure there was no residual food on their hands or faces. During the evening of our second visit, we saw a member of staff rearrange a person's dressing gown to ensure that they were appropriately covered while they were sitting in their chair.

There was an appointed dignity champion at the service. This member of staff monitored staff practices and ensured that people's dignity was promoted. One staff member said, "[Name of staff member] is dignity champion. She makes sure everyone is treating people with respect." Any issues or concerns relating to people's dignity were recorded in the "Dignity log." The last recorded entry was on March 2016. A member of staff had recorded that one person had food on their clothing. Dignity issues were also discussed during staff meetings. We read that the manager had informed staff that one person had been wearing another person's trousers which had not promoted their dignity.

We noticed that four people with a dementia related condition were not wearing any footwear. We considered that this did not promote their dignity or safety. Following our inspection, the manager told us that this had been addressed with staff.

Staff informed us that people's independence was promoted, this was confirmed by people. One person said, "I can manage to wash and dress myself. If you need help, you just need to ask." We saw that one person did not use their wheelchair foot rests so he could push himself around the home. We also noticed that staff had placed a reminder list on the back of their bedroom door so the person could check that they had remembered everything before they left their room. One person liked to help wash the dishes in the small kitchen area in the 'Internet café.' A member of staff told us, "[Name of person] likes to tidy up their own room and that's promoting her independence. She likes to do things for herself…If someone can wash their own hands and face, we would never take the face cloth away from them and do it ourselves, we would promote that and encourage them to do as much as they can themselves."

We found the care planning process centred on individuals and their views and preferences. Care plans contained information about people's life histories which had been developed with people and their relatives. We read that one person did not like "Bang bang, thump thump music" or water on their face. We noted that they liked feeding the birds, walking and gardening." Their care plan also stated, "[Name of person] has a lovely smile and likes to hold your hand when you are talking to him." This meant that information was available to give staff an insight into people's needs, preferences, likes, dislikes and interests, to enable them to better respond to the person's needs and enhance their enjoyment of life.

People and relatives said that they were involved in the care planning process. One relative told us, "I've now see his care plan and it's been updated and we have regular reviews." Another said, "Whenever her care plan changes they go through it with me." A third relative said, "They just went through her care plan with me again last week." We saw that pictures had been added to make the information easier to understand. One member of staff said, "We make sure people are involved in their care plans and will go through care plans with people and relatives." We observed a member of staff going through one person's care plan with a relative on the second day of our inspection.

The manager informed us that no one was currently using an advocate. Advocates can represent the views and wishes of people who are not able to express their wishes.

Good

Is the service responsive?

Our findings

At our previous inspection we identified shortfalls in the provision of activities and it was not always clear what action had been taken in response to complaints.

People, relatives and health and social care professionals were complimentary about the responsiveness of staff. One person said, "They help me, they help me to turn so I don't get sore and I'm doing well. I'm up for longer now." Another said, "The staff are smashing." Comments from relatives included, "They are quick to respond," "When my [relative] came in they had lots of problems with anger, they have done so well now, everything is sorted," "Nothing is a bother to them or a problem. I have no complaints, they are all very accommodating," "It's brilliant for dementia care" and "[Name of staff member] really made a point of looking after her, taking her to the shops. She will walk [name of person] to the chemist to get the prescriptions."

We spoke with the reviewing officer who told us, "I haven't had any complaints from relatives; I don't get any gripes [from relatives] about the care." The chiropodist said, "They are responsive. I saw a lady last week and her legs were red. I went to [name of staff member] and she was already aware and had organised for the GP to come in" and "I have never seen anyone [staff] not reply or answer or help them when they need assistance."

Preadmission assessments were carried out before people moved to the home to ensure that staff could meet their needs. If people had been admitted to hospital following an illness or accident, the manager told us that she always carried out an assessment to make sure that they could continue to meet their needs before they returned back to the home.

Each person had a care plan for their individual daily needs such as mobility, personal hygiene, nutrition and health needs. These gave specific information about how people's needs were to be met and gave staff instructions about the frequency of interventions. Care plans were regularly reviewed to ensure people's needs were met and relevant changes were added to individual care plans.

Staff were knowledgeable about people's needs and could explain these to us. We heard one member of staff ask a person, "Would you like some music on – not too loud I know" and "You used to work in a school didn't you [name of person]." One staff member said, "You like a Guinness don't you [name of person]?" "Oh yes" was the reply.

We checked how people's social needs were met. One person said, "There's enough going on. They do things – it keeps you going." A relative said, "They try their best with activities, however many residents have advanced dementia and it is difficult." There was an activities coordinator employed. She had recently returned to work after an extended period of leave. People, relatives and staff told us that they were glad to see her return. One staff member said, "[Name of activities coordinator] is bubbly and the families are happy she is back."

The activities coordinator told us, "I'm always looking for things to do and different ideas" and "I do a lot of one to one where I read and talk to residents, I do manicures, listen to music and have a little walk with residents. In the afternoon I do an activity and we do exercises, rather than keep fit, it is things like using the ball or we have a sing a long and move to the music so it's light hearted and we are getting them to move without them thinking they are exercising."

Staff also told us that they were involved in activities. One staff member told us, "They love music; you can tell if they are tapping their feet or moving their arms. We spend time talking to them and they like this." Another staff member said, "I took [name of person] to the dentist. But we didn't just go to the dentist, I took her shopping and we had a look around the estate where she used to live."

People's spiritual needs were met. This was confirmed by people and relatives with whom we spoke. A monthly church service was held.

Staff were aware of people's interests and hobbies. One person loved football and staff had laminated football cards for them and put them in a box together with a selection of football DVDs. Another person enjoyed gardening and we heard a staff member ask him, "Have you got tomato plants outside?"

Staff linked up the television to the internet to enable people to look at google maps so they could see where they lived. People also had access to Skype [internet communication system]. Staff supported one person to Skype their relative who lived in another country. Relatives informed us that they could visit at any time. This meant that staff supported people to remain in contact with their relatives and friends.

The service had an iPad and staff used this to show people photographs of past events and special occasions such as Christmas day, the Queen's birthday and parties. We saw the manager showing one person photographs of Christmas day and they were reminiscing about the presents that people received and the manager's Christmas jumper.

There was a complaints procedure in place. There had been three complaints received since our last inspection. We spoke with one relative who had raised a complaint. She told us, "The care is much better now [following their complaint]." There were copies of letters and details of what action had been taken in response to the complaints raised. We found that complaints had been dealt with in line with the provider's complaints procedure.

People and relatives told us that their views were always asked for. One relative said that they attended 'residents and relatives' meetings.' He told us, "It doesn't matter if you can't attend; you just discuss it with [name of manager]. You can bring up anything you want; [name of manager] is very good." Another relative told us that he was involved in producing the home's newsletter. He said, "I did their newsletter for them a few months ago." Surveys were also carried out for people, relatives and health and social care professionals.

Inadequate

Is the service well-led?

Our findings

At the previous inspection in May 2015 we identified a breach in good governance. We found that action to address concerns with the premises was not carried out in a timely manner.

Following our inspection the provider submitted an action plan. They stated that all actions would be met by March 2016. At this inspection in June 2016, we found that the registered provider had not followed their plan and legal requirements had not been met with regards to the premises and good governance.

We found significant concerns with the premises at this inspection. We read copies of reports which the manager sent the provider from the past 12 months. These identified concerns such as the uneven flooring, the condition of carpets and stair safety. We read a catering audit which had been completed by the cook. She had highlighted concerns with the crack in the freezer. The catering audit stated, "[Name of director] spoke to by manager on 8/6/16 he states it is fine."

Reports had also been sent to the new management company in January 2016 which detailed the same shortfalls. We spoke with the regional manager from this company about why they had not taken action regarding the concerns raised during this time. He informed us that they had only fully taken over the management of the service recently and could not take action prior to this because the budgets had not been agreed. The nominated individual told us, "Anything that needs money spent needs to go to the directors for approval."

The manager analysed accidents and incidents to monitor for any key trends or themes. We noted that although she highlighted any issues such as concerns regarding the environment, action by the provider was not always taken immediately to reduce the risk and likelihood of any reoccurrence.

We therefore found that a quality assurance system was in place to monitor all aspects of the service, however this was inadequate and ineffective since action was not taken in a timely manner to ensure the safety of all those concerned. Immediate action was only taken following our inspection and intervention. We read staff exit interviews. We noted that one ex member of staff had stated, "Employer relationship with CQC and commissioning not proactive – reactive."

Regular staff meetings were carried out. We saw that staff themselves had raised concerns about the environment during these meetings. They told us that the provider had not taken action to address these concerns. One staff member said, "It's exactly the same as you left it." Another staff member said, "The care is excellent, the environment is letting us down." We also read minutes from 'residents' and relatives' meetings.' We saw that the same environmental issues had been raised and no action had been taken. One health and social care professional told us, "It could do with updating, that is the feedback you get from family members."
This was a continuing breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

There was a registered manager in post. She had worked at the service for six years and been registered manager for four years. People, relatives and health and social care professionals were very complimentary about her. One person told us, "[Name of manager] is very nice, I like her. She's been the best one so far." A relative told us, "[Name of manager] is really great…When we first came we felt like the family from hell dropping her [relative] off, however [name of manager] was really reassuring." Comments from health and social care professionals included, "[Name of manager] is very helpful," "[Name of manager] is very receptive and interested and on the case with anything immediately" and "[Name of manager] is always cheerful – nowt's a bother."

Staff were also complimentary about the support they received from the manager. Comments from staff included, "[Name of manager] has been marvellous, absolutely fantastic. I couldn't have asked for more support," "[Name of manager] is very fair. Everything is dealt with straight away…Her door is always open" and "[Name of manager] is 100% supportive. I don't think we can fault her about anything."

The deputy manager had left the service in September 2015. The manager told us, "I have found it very difficult to be fair. I have had to cover the deputy manager's role. I also have to be on the floor since the deputy manager was my eyes and ears. We only have 13 hours admin, so I also have to answer calls and because the deputy manager was the first port of call, she used to field any queries, but now all queries come to me." The manager told us that a new deputy manager had been appointed and they were awaiting their recruitment checks before they started work.

Staff told us that the service had been through a period of uncertainty. They told us that there had been changes in the provider's management structure. Although the provider's legal entity remained the same - 'North East Care Homes Limited,' a new management company was now overseeing the service; this had been the second management company within 12 months. Staff told us that these changes had affected morale. One staff member said, "We have been a bit concerned seeing different people [from the two management companies] come in. It's a bit daunting and upsets staff a little because we worry what is happening and what the future holds." They said however, that this had not affected the care that they provided.

An employee of the month scheme had been introduced. Successful staff got a certificate and a small gift. The manager told us, "It's just to recognise staff and we try and get residents and relatives to nominate staff who have gone over and above."

The previous CQC inspection ratings were clearly displayed at the service in line with legal requirements. We noticed however, that their CQC ratings were not clearly displayed on their website. We spoke with the provider's representative who told us that this would be addressed.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that the premises were safe for people who used the service and others. Some of the decor and furnishings were damaged which meant that they could not easily be cleaned which was an infection control risk. Regulation 12 (1)(2)(d)(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Not all staff had carried out training to meet people's specific needs such as falls awareness, continence care, activities provision, Parkinson's Disease and pressure area care to ensure that staff were able to carry out their duties safely and effectively. Regulation 18 (2)(a).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system in place to assess, monitor and improve the quality and safety of the service because action to address the premises shortfalls was not taken in a timely manner. Regulation 17 (1)(2)(a)(b)(e)(f).

The enforcement action we took:

We issued a warning notice