Grovewood House

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on the 9 May 2017 and was unannounced. This meant the provider and staff did not know we would be visiting. We carried out a further two announced visits to the home on the 10 and 12 May 2017 to complete the inspection.

At our last inspection on 9 March 2016, we found two breaches of the Health and Social Care Act 2008. These related to safe care and treatment and good governance. We rated the service as requires improvement.

At this inspection we found that action had not been taken to improve in all areas and we identified further shortfalls in relation to other areas of the service.

Grovewood House is a family run care home and opened over 20 years ago. It was originally built in 1863 as a Vicarage. It accommodates up to 28 older people, some of whom are living with dementia. There were 25 people living at the home at the time of the inspection.

The provider was a husband and wife partnership. Their two daughters and son were involved in the management of the service. One of their daughters was the registered manager of the care home and their son was the registered manager of the home care service. 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.

The home care service however, was no longer being carried on at the care home and was registered separately. The provider had not applied to remove the homecare regulated activity from the care home's registration. Both registered managers told us that this would be addressed. Regulated activities are services which are delivered by the provider.

We identified serious shortfalls and omissions in relation to checks and tests of the premises and equipment to demonstrate their safety. Risk assessments were not always specific or accurate.

One person had sustained an unobserved injury. Records relating to this accident were not detailed. In addition, there was no recorded investigation into the events leading up to or following the injury to identify if action needed to be taken to mitigate any risks.

The adaptation, design and decoration of the home did not fully meet the needs of people with a dementia related condition. In addition, the environment did not fully promote people's privacy, dignity and independence.

On the first day of our inspection, we had concerns with the storage of certain medicines. This was addressed by the second day of our inspection. Not all staff on night duty had completed medicines

training. Staff would contact the registered manager of the home care service if medicines needed to be administered overnight. This issue had not been risk assessed.

Records did not always evidence that safe recruitment procedures were followed.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found shortfalls regarding the maintenance of records relating to the MCA. DoLS assessments had not been updated following the Supreme Court judgement in March 2014. This meant there was a risk that DoLS assessments did not accurately assess whether people's plan of care amounted to a deprivation of liberty to ensure people were not being unlawfully deprived of their liberty. Mental capacity assessments had not been carried out for all specific decisions.

There were safeguarding procedures in place. Staff knew what action to take if abuse was suspected.

There were sufficient staff deployed to meet people's needs. We saw that staff carried out their duties in a calm unhurried manner and had time to provide emotional support to people. Staff told us there was sufficient training. The provider had appointed an individual to deliver specific training.

We observed that staff supported people with their dietary requirements. We observed positive interactions between people and staff. An activities coordinator was employed to help meet the social needs of people. A varied activities programme was in place.

We found the provider was failing to assess, monitor and mitigate the risks in relation to the safety and welfare of people. A quality assurance system was in place. We noted however, that this was tick box in style and had not identified the concerns and shortfalls which we had found during our inspection regarding equipment, the premises and Mental Capacity Act. Accurate and complete records were also not maintained in relation to people, staff and the management of the service.

Since 2011, we found the provider was breaching one or more regulations at six of our 10 inspections. Most of these breaches related to regulations regarding the premises and governance of the service. At this inspection we identified further concerns and shortfalls and breaches of regulations. This meant that compliance with the regulations was not sustained and consistency of good practice was not demonstrated.

The provider was not meeting all the conditions of their registration. They had not submitted notifications of all deaths in line with legal requirements. The submission of notifications is a requirement of the law. They enable us to monitor any trends or concerns within the service. This meant there had been no overview by the Commission to check whether the appropriate action had been taken.

Despite our findings and the shortfalls we identified. All people and relatives spoke positively about the home and rated it as good or outstanding. Staff informed us they were happy working at the service and morale was good. We observed that this positivity was reflected in the care and support which staff provided

throughout the day.
The overall rating for this service is 'Inadequate' and the service is therefore 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 identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment, premises and equipment and good governance. We also identified a breach of the Registration Regulations 2009 which related to the notification of deaths at the service.

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?

Inadequate

The service was not safe.

We identified serious shortfalls and omissions in relation to checks and tests of the premises and equipment to demonstrate their safety.

Risk assessments were not always specific and risk assessments relating to the use of the bath hoists were not accurate.

Records did not always document the recruitment checks and decisions which had been undertaken. There were sufficient staff deployed to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Records did not fully evidence how staff were meeting their obligations under the Mental Capacity Act 2005.

The adaptation, design and decoration of the home did not meet the needs of people with a dementia related condition.

Staff told us that there was sufficient training at the service. Not all night staff had completed medicines training.

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

Is the service caring?

Requires Improvement

The service was not always caring.

Certain aspects of the environment did not promote people's privacy, dignity and independence.

Staff were attentive and kind to people during the inspection. People told us they felt well cared for. Relatives spoke positively about the caring nature of staff.

People and relatives told us they were involved in their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Records did not always evidence that responsive and safe care was provided.

People's social needs were met. A range of activities were available.

A complaints procedure was in place. No complaints had been received.

Is the service well-led?

Inadequate

The service was not well led.

We found serious shortfalls with aspects of the service including the premises, equipment, MCA and the maintenance of records. These had not been highlighted by the provider's quality monitoring system.

The provider was not meeting the conditions of their registration. They had not notified us of all deaths at the service.

Despite our findings and identified shortfalls with the service people and relatives were very positive about the service.

Grovewood House

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 inspection took place on 9 May 2017 and was unannounced. We carried out two further announced visits to the service on the 10 and 12 May 2017 to complete the inspection. The inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to carrying out the inspection, we reviewed all the information we held about the home. The registered manager completed a provider information return (PIR). 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.

We contacted Northumberland local authority safeguarding and contracts and commissioning teams prior to our inspection. We also contacted Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used their feedback to inform the planning of this inspection.

We spoke with six people and two relatives on the day of the inspection. We also spoke with two relatives by phone following our inspection. We conferred with a nurse specialist and a social worker from the local NHS trust.

We spoke with the registered manager of the care home, the registered manager of the home care service, the activities coordinator, two chefs and three care workers.

We viewed three people's care plans. We also looked at information relating to staff recruitment and training. We examined a variety of records which related to the management of the service.

Following our inspection we referred our concerns to the local authority contracts and safeguarding teams, the local authority's environmental health [health and safety] officer and Northumberland fire and rescue team.

Inadequate

Is the service safe?

Our findings

At our last inspection we identified a breach in regulation 12 which relates to safe care and treatment. We found that some radiators covers would not fully protect people from the risk of injury should someone fall against them, wardrobes were not fixed to the wall to prevent any accidents or incidents and one person's bed rails did not fully meet the Health and Safety Executive's guidelines to prevent injuries or entrapment.

At this inspection we found that action had been taken to address several of the shortfalls identified at our last inspection, however, not all actions had been completed.

Wardrobes were now fixed to the wall. The registered manager of the home care service told us that no one was currently using bedrails. Not all radiator covers however, would fully protect people from the risk of burns. The registered manager of the home care service told us that they were replacing the covers on an ongoing basis.

At this inspection we identified new concerns, omissions and shortfalls relating to the premises and equipment. Water temperature checks had not been completed since 2015 to identify and monitor the risk of Legionella. Annual checks of the safety of gas appliances had not been carried out since 2015 and there was no evidence that the fire alarm system had been serviced since 2015. This meant that checks and tests had not been carried out in line with legal requirements to ensure the safety of the premises.

A fire audit had been completed by a fire safety inspector in 2013. This stated that every member of staff had to undertake at least two fire drills a year. We noted that records did not evidence that staff had been involved in the required number of fire drills to ensure they understood the actions to take in the event of a fire.

Checks and tests of moving and handling equipment had not been carried out within the correct timescales. One person had slipped off the bath seat hoist in the downstairs bathroom. There was no safety belt attached to the seat. We noted that the safety belt on the upstairs bath hoist had been cut off. We considered that the provider had not ensured that equipment was safe, suitable and serviced in line with legal requirements.

One person had sustained an unobserved injury. Records relating to this accident were not detailed. In addition, there was no recorded investigation into the events leading up to or following the injury to identify if action needed to be taken to mitigate any risks.

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

The registered manager of the home care service currently monitored health and safety at the care home. He told us they were looking to appoint an individual to carry out health and safety checks since his time was taken up overseeing the management of the separately registered home care service.

Following our inspection, the registered manager of the home care service contacted us to state they were sourcing a company to carry out servicing on the moving and handling equipment. He also stated that a gas engineer was attending the home on 22 May 2017 to check their gas appliances. He said the fire alarm had been serviced, however the company they used had not sent them a service certificate and he was in the process of chasing this up.

Safe recruitment procedures were not always followed. We checked the recruitment records of the last staff member employed. References had been obtained, however a Disclosure and Barring Service [DBS] check had not been received. DBS checks ensure staff working at the home have not been subject to any actions that would bar them from working with vulnerable people. The staff member told us they were currently shadowing a member of staff. No risk assessment had been completed in relation to this issue. In addition, there was no evidence of interview records to demonstrate how the provider had assessed the suitability of the staff member to work at the home.

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

Following our inspection, the registered manager of the home care service informed us they had received a DBS Adult First check to make sure the staff member was not on the barred list from working with vulnerable adults. They also stated that DBS check had now been received.

Risk assessments had been completed following an assessment of people's care. Risk assessments had also been completed in relation to general risks such as the stairs and bathing. We noted however, that risk assessments were not always specific. Risk assessments in relation to falls had been graded as low, medium or high. It was not clear how staff had assessed the grading of each risk since a recognised assessment tool was not in use. Risk assessments relating to the use of the bath hoists were not accurate.

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

Following our inspection, the registered manager of the home care service contacted us to state that the risk assessments had been amended and updated.

We checked the management of medicines. Medicines were stored in an unlocked room adjoining the kitchen. There was access to this room from the garden. Most medicines were stored in lockable cupboards. On the first day of our inspection, we noticed that keys to the cupboard where topical creams and ointments were stored were left in the cupboard. In addition some people's inhalers, eye drops, ear drops and angina medication were stored on the window sill. This meant that medicines were not always stored safely to ensure their effectiveness. On the second day of our inspection, this had been addressed and all medicines were locked away.

Not all night staff had completed medicines training. The registered manager of the home care service lived nearby. He said that staff would wake him up if assistance with medicines was required overnight. However, we were concerned that this may cause a delay in people receiving their medicine. This issue had not been risk assessed. Following our inspection, the registered manager of the home care service told us there were two night staff who had completed medicines training and they covered all shifts at the home. He said he would cover during any holidays. He also stated, "We are looking to put all night staff on medication courses." We checked medicines administration records and noted that these were completed accurately.

People and relatives told us they considered people were safe at the service. Comments included, "Oh, I feel safe, yeah; I don't think anything'll happen to me," "Yes [I feel safe] because I'm comfortable here. The people look after us well; I've no negative feelings about them," Yes, yes [she is safe]. Because the staff look to see how she is and she doesn't seem to have any problems," "Yes [relative is safe]. There's locks on the doors, 'cos me [relative] tends to wander. There's always staff around," "Yes [relative is safe] It's just a feeling. I'm happy with what I see," "Oh definitely [safe]; she escaped from the last place after four days," "Yes [relative is safe]. Well, he wasn't safe at home and he's well looked after there" and "Yes, absolutely [safe]. They have good control of the entrance and they're very aware of where everyone is."

There were safeguarding procedures in place. Staff knew what action to take if abuse was suspected. The local authority safeguarding team told us that there were no organisational safeguarding concerns regarding the home.

Most people and relatives told us there were sufficient staff deployed. Comments included, "There's always plenty of people about," "From what I see, I would say so [enough staff]. They always seem to be very patient with them," "Well, I think there was once or twice when there weren't enough; there were quite enough the other day when I went up" and "I would say so [enough staff]. When I visit, there always seems enough to cover."

A staffing tool was used to assess the numbers of staff on duty. This was linked to dependency levels. Throughout our inspection we observed that staff carried out their duties in a calm unhurried manner. Call bells were answered promptly. No call bells took longer than 30 seconds to answer on the days of our visit. At night there were two or three care workers on duty. The registered manager of the home care service lived nearby and was contacted if any extra support was required.

Requires Improvement

Is the service effective?

Our findings

.At our previous inspection we identified concerns with moving and handling practices at the home. Some staff had not had refresher training in this area since 2007. Some night staff had not completed medicines training. We also found that mental capacity assessments had not been carried out for all important decisions.

At this inspection we found that improvements were still required with regards to the Mental Capacity Act and medicines training.

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 authorisation 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.

The registered manager of the care home had submitted five applications to the local authority to authorise. She told us that 19 of the 25 people living at the service had a dementia related condition. A DoLS checklist was in use to ascertain whether people's plans of care amounted to a deprivation of liberty. However, this had not been updated following the Supreme Court judgement in March 2014. The Supreme Court referred to the 'acid test' that people were deprived of their liberty if they were under continuous supervision and control, not free to leave, and lacked the capacity to consent to these things. This meant there was a risk that DoLS assessments did not accurately assess whether people's plan of care amounted to a deprivation of liberty to ensure service users were not being unlawfully deprived of their liberty.

Mental capacity assessments had been carried out when people had come to live at Grovewood house to assess whether people had capacity to make this important decision. We noted however, that mental capacity assessments had not been carried out for other specific decisions such as the use of sensor alarms which alerted staff if the person moved and were at risk of falling. We also saw that information was available with regards to voting. We noted that some records stated that the person lacked capacity to vote, however a mental capacity assessment had not been carried out to assess this decision. Following our inspection, the registered manager of the home care service told us that this had been addressed.

Information relating to whether people had appointed a lasting power of attorney (LPA) was not available. 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. This meant evidence was not available to confirm whether an attorney had been appointed or what type of LPA was held to ensure the correct

attorney was involved in the correct decisions.

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

We checked how the adaptation, design and decoration of the premises met people's needs. People and relatives told us they were happy with the homely environment. One relative told us that the décor and furnishings were not to their taste, but they suited their family member's preferences.

The National Institute for Health and Care Excellence (NICE) states, "Health and social care managers should ensure that built environments are enabling and aid orientation." We found that not all of the premises were "enabling" and helped aid orientation.

There was limited signage to highlight bedrooms, communal areas of the home and toilets. Some of the décor and furnishings were worn in areas. The plastic covering on several of the armchairs in the lounge was damaged.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 15. Suitability and safety of premises.

People and relatives told us that staff met their needs effectively. Comments included, "Yes [they know what they are doing]. I can't be specific, but I've never felt incompetently handled," "They all know now, the help I need," "They manage her anxieties very well," "They seem able to handle him well enough. I think the staff are great to manage him when he's aggressive" and "They always know how to deal with her."

At this inspection we found that refresher training in moving and handling had been undertaken. We did not observe any inappropriate moving and handling techniques. The registered manager of the home care service told us that two night staff had completed training in medicines management. He stated that they were going to put all night staff through medicines training.

All staff informed us that they felt equipped to carry out their roles and said that there was sufficient training available. Comments included, "We have lots of training. We have training on everything – moving and handling, dementia. We're all trained here – we don't just get someone off the street if you know what I mean, who says 'I want to be a carer' and they are just left to get on. Everyone is qualified here," "I'm busy doing courses at the minute. I'm doing one on palliative care" and "[Name of registered manager] always says, better qualifications, better for the residents." The provider had appointed a trainer and had signed up to the local NHS Trust's online training system.

Induction training was completed to make sure that staff had achieved acceptable levels of competence in their job role. This was not yet linked to the Care Certificate. The Care Certificate is a set of nationally recognised standards to be covered as part of induction training of new care workers. The registered manager of the home care service told us their trainer was going to introduce the Care Certificate in the near future.

All staff told us that they felt supported in their roles. Staff told us they had supervision. There was an appraisal system in place. Supervision and appraisals are used to review staff performance and identify any training or support requirements.

People's nutritional needs were met. People and relatives were positive about the meals at the service.

Comments included, "Oh, there's plenty of that [food]; we won't starve. Generally, it's pretty good. There's always a glass of water here [in room] and I can ask for a drink when I want one. We get plenty of cups of tea, which is nice," "Well, it looks nice when I've seen it. I can see on the menu board what it is and it always sounds quite good," "She's always got a cup of tea. Gran always comments on how nice the food is" and "The food is very good; the food is absolutely lovely – the quality etcetera. When we visit, she's always given a cup of tea with my husband and I."

There were two sittings at meal times due to the size of the dining room and the support which people needed. Those who required more support attended the second sitting. We noticed however, that one person with a dementia related condition who was on second sitting was trying to eat another person's lunch who was on first sitting. A staff member reassured the person that their meal would be coming soon. The person however, did not understand and continued to try and eat this person's meal. We spoke with the registered manager of the care home about our observations and whether this individual could be offered a snack whilst they were waiting for their meal. On the third day of our inspection, the registered manager of the care home told us that staff were offering the person a small snack before their meal which had worked.

Two chefs were employed at the service. They were knowledgeable about people's needs and could describe these to us. They told us and our own observations confirmed that there was an emphasis on home baking. Fruit was prepared each morning and offered to people.

Staff were also aware of people's dietary needs. One staff member said, "[Name] loves strawberries and she hasn't been very well. Sometimes she will have strawberries and cream for breakfast. If you're poorly, you just want what you fancy, so we always ask."

People and relatives told us that staff contacted health care professionals to meet people's specific needs. Comments included, "I think if you really wanted one, they would get you one [a GP], but I've not needed to see anyone," "I was told when the doctor came to visit her," "When they had the doctor out recently, they told me about that" and "If he's needed a doctor, they've asked for one. He's had new glasses as well." One person told us that she would like to see dentist. The registered manager of the care home told us that this would be arranged.

We saw evidence that staff had worked with various agencies and accessed other services when people's needs had changed, for example, consultants, GP's, district nurses, speech and language therapist, dietitians, the chiropodist and dentist. This demonstrated that the expertise of appropriate professional colleagues was available to ensure that the individual needs of people were being met to maintain their health.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us that staff promoted people's privacy and dignity. Staff were respectful in their approach with people. We noted however; that certain aspects of the environment did not promote people's privacy and dignity nor promote their independence. There was limited signage to indicate certain areas of the home such as toilets. There was no blind in the upstairs bathroom which overlooked the main entrance. Washable chair protection pads were placed over some fabric armchair cushions in case of incontinence. We considered that they could draw attention to the potential problem and therefore compromise people's dignity.

People and relatives told us that staff were caring. Comments included, "Oh, they're very good. They're always welcoming and call me by my first name. They always question me about how I feel about things. They're always cheery," "They're all lovely and do a job not many of us could do," "Oh, they're all very friendly," "The staff are perfect; they're always very good," "Always very friendly, really nice. They like to joke with them [people]" and "They have patience and respect." The nurse specialist told us, "There is a good level of support with end of life care."

Staff spoke with pride about the importance of ensuring people's needs were held in the forefront of everything they did. One staff member said, "Here is like a home. When you come in and you see the residents smiling it is lovely. We have a special thing with the residents. Sometimes they like a kiss on the cheek. Here is not like a care home, it's like a home. We try and do the best we can. We know what they like, even how they like their tea – we know. We never say, it's 7 o'clock everyone to bed - it's their choice. We try and think what it would be like to live here and we try and make it home."

Staff displayed warmth when interacting with people. They were very tactile in a well-controlled and nonthreatening manner. One person reached out for a hug which was immediately given by a member of staff. Relatives and visitors were welcomed into the home. One relative visited the home regularly and had their lunch with their family member for which there was no charge.

A person centred care plan was in place which gave details of people's likes and dislikes. One staff member said, "We know the residents and what they like." Another staff member said, "It's all about knowing their little ways. I find a bit of humour always helps."

People and relatives told us that they were involved in people's care. Comments included, "Very much [involved]. We always have a bit chat when I come," "I've come in today in fact, to speak about end of life care" and "If there's anything to discuss, they always take us into the office and we have a chat."

Requires Improvement

Is the service responsive?

Our findings

We found that records did not always evidence that responsive and safe care was provided. Staff did not document details of the care provided on each shift. Night staff had not recorded the care provided prior to one person's unobserved injury to document their behaviour and any events leading up to the injury.

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

Each person had a plan of care. Staff documented people's care and support in a number of areas including their personal care, mobility needs, emotional and spiritual care. Sometimes staff would record a review of the person's care on this plan which meant it was not always clear how the care and support should actually be provided. For example, staff would record what social activities the person had undertaken during the month, but not recorded how their social needs should be met. A person centred plan was also available which included details of the person's life history together with their likes and dislikes.

People and relatives told us that staff were responsive to people's needs. Comments included, "It's just wonderful what they do there and everyone is so nice" and "They take their time to answer questions and alleviate concerns."

We spoke with a social worker from the local NHS Trust. She told us, "I have always found them to be very professional. What I like as well is that they will go out and assess people, but if they feel they can't meet their needs they will say…Family members are happy with the care. I have always found that they are timely in their responses and respond quickly to anything that is flagged up…They make appropriate referrals."

One of the senior care workers had 20 designated hours each week to provide activities provision. People and relatives told us that people's social needs were met. Comments included, "People go in and talk to her; she's not left on her own," "She can't manage to do a lot, but there's always lots going on; crafts, jigsaws, painting and Easter bonnets at the time. If she was able to do, it's there," "Yes, she gets involved in lots of things. She likes art and those sorts of things. She's also involved in the Skylarks." Skylarks is a creative engagement group which incorporates music, drama and poetry. The sessions were organised by an external group work facilitator and were held weekly. Exercise sessions were held once a fortnight by a personal trainer and an artist visited the home to support people with various artistic projects. A therapy dog visited every Tuesday and Shetland ponies had also visited. On the second day of our inspection people were going to a classical music concert at Alnwick Gardens.

The activities coordinator told us that she carried out group and individual activities. She said, "[Name] likes her music – she responds well to music. I tend to do this through the iPad." She also explained that another person used to be a short hand typist. She said, "I found a video which I played about short hand typing and she was smiling from ear to ear and trying to copy the short hand."

People had access to the outdoors. We saw two people with a dementia related condition doing their own

impromptu exercise session in the garden which involved running and skipping around the garden. When they came back into the home one person told us, "That was good." Another person was gardening and others enjoyed sitting in the garden or feeding the tame pheasant which people had named Percy. The activities coordinator told us that sometimes Percy brought his lady friend Penelope into the garden!

There was a complaints procedure in place. No complaints had been received. People and relatives with whom we spoke did not raise any complaints.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on 9 March 2016 we rated the well led question as requires improvement and identified a breach of regulation 17, good governance. We stated, 'Although audits and checks were carried out on various aspects of the service, these had not always highlighted the shortfalls which we had found during our inspection such as those concerning the premises, equipment, mental capacity and care plans." We requested an action plan to be sent to the Commission describing what actions the provider was going to take to improve. We did not receive an action plan in line with legal requirements.

At this inspection, the registered manager of the home care service told us he did not know why we had not received an action plan since this had been completed. He provided us with a copy for our records.

We identified continuing concerns and shortfalls in relation to equipment, the premises, MCA and the maintenance of records.

One person had sustained an unobserved injury. Records relating to this accident were not detailed. In addition, there was no recorded investigation into the events leading up to or following the accident. Most accidents and incidents were recorded on an accidents and incidents proforma. However, others were documented in people's communication records. We read one person's communication records and noted that some behavioural incidents were documented and an unobserved fall. It was therefore not possible to gain an overview of all accidents and incidents at the home without checking each person's care file to ensure that the correct action had been taken.

A formal documented accident analysis was not undertaken. The registered manager told us that accidents and incidents at the service occurred infrequently and if any trends were identified the home care registered manager would carry out a detailed analysis using graphs.

Staff did not always record the care and support provided to people on each shift. The registered manager told us that any changes in people's condition, visits by health and social care professionals, social activities or any other important events were always documented. This meant it was not possible to check the care and support provided to people on each shift including night shift.

We found concerns and omissions regarding the safety of the premises and equipment. Records of some checks and tests were not available. The registered manager of the home care service told us that he currently monitored health and safety, however, they were thinking of appointing a designated person to carry out the necessary checks because he was busy overseeing the management of the separately registered home care service which took up a lot of his time. This meant an effective system was not in place to ensure the safety of the premises and equipment.

There were shortfalls regarding the maintenance of records relating to the MCA. DoLS assessments had not been updated following the Supreme Court judgement in March 2014. Information relating to whether people had a LPA was not available and mental capacity assessments had not been carried out for all

specific decisions.

We also identified shortfalls in the maintenance of records relating to staff recruitment. Records did not always evidence that the correct actions had been taken to ensure that staff were suitable to work with vulnerable people.

These shortfalls and omissions had not been highlighted by the provider's quality monitoring system. We looked at the last quality audit which had been completed in January 2017. The audit was tick box in style and most areas had been rated '5' – "No significant shortcomings" which was the highest score.

Since 2011, we found the provider was breaching one or more regulations at six of our 10 inspections. Most of these breaches related to regulations regarding the premises and governance of the service. At our last inspection in March 2016 we identified two breaches relating to safe care and treatment and good governance. We rated the service as requires improvement. At this inspection we found that improvements had not been made and identified four breaches of the regulations. This meant that compliance with the regulations was not sustained and consistency of good practice was not demonstrated.

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

We checked whether the provider was meeting the conditions of their registration and notifying us of all changes and events at the service in line with legal requirements. The submission of notifications is a requirement of the law. They enable us to monitor any trends or concerns within the service. We found the provider had not notified us of eight deaths at the service. This meant there had been no overview by the Commission to check whether the appropriate action had been taken and no concerns had been identified.

The registered manager informed us that the registered manager of the home care service normally submitted the notifications. The home care registered manager told us however, that he was overseeing the management of the home care service which took up most of his time. We considered an effective system was not in place to ensure that notifications were submitted to the Commission.

This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009. Notification of deaths.

The provider was displaying their previous CQC performance ratings on their website. We noted however, they were not displaying their ratings at the home in line with legal requirements. The care home registered manager told us that she was now aware of her responsibilities and this would be addressed immediately.

The provider was a husband and wife partnership. The care home was managed by the provider's two daughters and son. There were two managers currently registered with CQC at the service. One oversaw the care home and the other was registered in respect of the home care service. The home care service was no longer being carried on at the care home and was registered separately. The provider however had not applied to remove the homecare regulated activity from the care home's registration. Both managers told us that this would be addressed. Regulated activities are services which are delivered by the provider.

Despite our findings and identified shortfalls, people and relatives were very positive about the care home. They all rated it as good or outstanding. Comments included, "It's outstanding. We've just never had any problems" "I would [recommend it] because it's more homely here," It appears to be very well managed," "It's family-run and it's just like talking to family really."

People, relatives and staff were involved in the running of the service. Surveys and meetings were carried out. The registered manager of the care home service told us she was going to send out questionnaires for the 2017 survey. One staff member said, "Our bosses are good. They ask us what we think and between us we think of what is best. If we have any ideas we just go to [names of registered managers]. Everyone works together here for the good of the residents; it's not just down to one person."

Staff were very positive about working for the provider. They said they felt supported, valued and enjoyed working at the home. One staff member said, "I love my job" The provider also organised free transport to bring staff to and from work. We observed that this positivity was reflected in the care and support which staff provided throughout the day. Staff responded positively to any requests for assistance and always sought to be complimentary when speaking with people.