Care UK Community Partnerships Ltd

Armstrong House

Inspection report

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Date of inspection visit:
03 May 2016

Date of publication:
13 June 2016

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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 26, 29 and 30 October 2015. Six breaches of legal requirements were found.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements. These related to breaches of regulations regarding safe administration of medicines, supporting staff, consent to care and treatment, person-centred care, complaints and governance.

We undertook a focused inspection on 3 May 2016 to check the progress the provider had made in implementing their action plan. During the course of the inspection we also followed up on some concerns that had been raised with us. This report only covers our findings in relation to those requirements and the concerns. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Armstrong House on our website at www.cqc.org.uk.

Armstrong House is a care home providing accommodation and nursing care for up to 71 older people, some of whom have a dementia-related condition. At the time of the inspection 64 people were living at the home.

The registered manager had left in the period since our last inspection. A new manager was in post at the time of this inspection who informed us they were in the process of registering.

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

The provider had made improvements to the management of medicines and introduced a new system to improve the recording of topical medicines. However, records did not demonstrate that topical medicines were being consistently applied.

The provider had reviewed the provision of staff training and made the necessary arrangements for staff to undertake training within specified timescales. The provider had taken action to ensure all staff members were scheduled to receive six supervisions and an annual appraisal in line with their policy and procedure for supporting staff.

The provider had improved the process for acting on complaints and updated the service user guide to ensure people were made aware of the complaints procedure.

Although some improvements had been made to further personalise care records, people's consent to care and treatment was not always being obtained to uphold their rights.

We concluded that the provider was making good progress towards their action plan and will check whether the improvements have been sustained at our next comprehensive inspection.

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 consistently safe.

Medicines were suitably stored.

The records of topical medicines application remained inconsistent.

Best interest decisions had been made in line with NICE guidelines for covert medication administration.

There were sufficient numbers of staff to meet people's needs safely.

We could not improve the rating for 'Is the service safe' from 'requires improvement' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements had been made to the support given to workers. Supervision and appraisals had been scheduled for all staff and there was evidence these had started to take place.

Training requirements for staff had been identified and appropriate training sourced and scheduled for completion in the near future.

Care plans had been reviewed and updated but consent to care and treatment records were not complete in all of the care records we viewed.

We could not improve the rating for 'Is the service effective' from 'requires improvement' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service caring?

Good

The service was caring. People told us they were able to get up and go to bed when they wished.

Staff demonstrated a sensitive and caring manner in their interactions with people and did not appear to be rushed.

Is the service responsive?

Requires Improvement

We found action had been taken to improve the responsiveness of the service.

Improvements had been made to the process for acting on complaints.

Care records had been reviewed to include additional detail about people's social and spiritual needs and how they should be supported to meet these needs.

We could not improve the rating for 'Is the service responsive' from 'requires improvement' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

We found action had been taken to improve the management of the service.

Improvement had been made to the process for acting on issues identified during audits. The manager was using the service improvement plan to capture areas for improvement from all audits undertaken and these were being acted upon.

We could not improve the rating for 'Is the service well-led' from 'requires improvement' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Armstrong House

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Armstrong House on 3 May 2016. This inspection was carried out to check the progress the provider had made against their plan to meet legal requirements after our comprehensive inspection on 26, 29 and 30 October 2015. During the course of this inspection we also followed up on concerns we had received about staffing levels, inappropriate staffing ratios and people being made to get up and go to bed early for the convenience of staff.

We inspected the service against the five questions we ask about services: Is the service safe?; Is the service effective?; Is the service caring?; Is the service responsive?; and Is the service well-led? This was because the service was not meeting a number of legal requirements at the time of our comprehensive inspection.

This inspection was undertaken by two adult social care inspectors. During the inspection we toured the building and talked with three people living in the home and a visiting health professional. We spoke with the manager, the deputy manager and seven care and ancillary staff.

We looked at twelve people's care records, staff training and supervision records and other records relating to the management of the service. We also carried out a 'short observational tool for inspectors' (SOFI) in a communal area to gather the experiences of people who could not communicate with us verbally.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in October 2015 a breach of legal requirements was found. Suitable arrangements were not in place for the safe administration of medicines. We reviewed the action plan the provider sent to us following our comprehensive inspection. This gave assurances that action was being taken to improve the administration of medicines.

At our last inspection we saw gaps in the topical medicines application records, photographs missing from some of the Medicine Administration Records (MAR) for one of the nursing units and best interest decisions for two people who received their medicines covertly did not comply with the recognised National Institute for Health and Clinical Excellence (NICE) guidelines. We also found areas for improvement identified during medicines audits were not being addressed and found one medicine was stored in the fridge when this was not required.

During this inspection we observed a medicines round on one of the nursing units. The staff member who administered medicines checked people's medicines on the MAR prior to giving them to ensure people received the correct medicines. Where people were prescribed pain relief on an 'as required' basis we observed the staff member asked people whether they required this medicine prior to administering. The staff member explained to people what the medicines were prior to administering them and asked people for their consent. People were offered a drink to assist them in taking their tablets. We witnessed the staff member stayed with people to ensure they had taken their medicines before returning to complete the MAR. All MARs we viewed as part of this medicines round contained photographs of the people using the service. This meant staff were able to identify the correct person was receiving the medicine.

We reviewed the storage of medicines. Dates had been recorded of when medicines had been opened. Although we found one medicine was stored in the fridge when the label indicated this was not necessary we were advised by the nurse this was on the advice of the doctor.

We looked at records and care plans for people who received their medicines covertly. This is where it has been agreed that people's medicines should be given to them without their knowledge or consent as it is in their best interests for this to happen. The records showed the correct decision making process had been followed and relevant people, including the GP and pharmacist had been involved in the discussion and final decision. This had been clearly recorded and was kept under review by the service. The staff we spoke with about the use of covert medicines were clear about the process that needed to be followed to approve this.

We looked at topical creams and ointment charts and care plans for five people. We found these were not consistent in that details about where and when the creams were to be applied were not recorded. Handwritten entries had not been countersigned to avoid errors. We also found records did not demonstrate that creams were being applied as frequently as prescribed. For example, one cream was to be applied daily and over the previous two weeks there were only signatures to indicate it had been applied on three days.

A new system to record the application of topical medicines had only recently been introduced. However, we found the level of detail around the application of these medicines remained limited. We concluded that records of topical medicines lacked detail and were not consistently completed meaning it was not possible to determine whether these had been administered as prescribed. Recent audits of medicines had highlighted areas for improvement and there was evidence these had been addressed through the service improvement plan.

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

As a result of concerns we received we spoke to the manager about staffing levels and staffing ratios to determine whether these were appropriate to meet people's needs.

The manager told us staffing levels in the service had been calculated using a tool that assessed the dependency of residents. Although this had not been reviewed since the new manager joined the service in February 2016, they felt staffing levels were appropriate. This was supported by comments from staff and people using the service who all felt the staffing levels were sufficient. Our observations were that staff were not rushed and were able to attend to people's needs in a timely manner.

The service used agency staff on a regular basis. The manager advised the service had a relationship with an external agency and that continuity of care was achieved through the use of the same agency staff. The service had recently completed a recruitment exercise to fill outstanding vacancies. The manager advised new staff members were currently in the process of undergoing pre-employment checks. Once complete, the appointment of these additional staff members would reduce the amount of agency staff used by the service.

The manager told us both male and female care staff were always on duty both day and night to cater for people's preferences. However the service had previously had a higher number of male care staff on duty at night. The manager advised three additional members of female night care staff had been appointed during the recent recruitment exercise, which would make the ratio of male/female care staff on a night more appropriate.

Staff we spoke with told us they felt able to raise any issues about safety to the new manager and deputy. One staff member told us, "Things have improved lately, some staff who didn't work hard have left and I think it's a happier home now."

Requires Improvement

Is the service effective?

Our findings

At our last inspection in October 2015 breaches of legal requirements were found. Staff had not been given the on-going training they needed to keep their knowledge up to date. Nor had they been given the necessary support, in terms of supervision and appraisal. People's care records did not contain records of their consent to care and treatment.

We reviewed the action plan the provider sent to us following our comprehensive inspection. This gave assurances that improvements would be made in the training and support given to workers. It also gave assurances that all care records would be reviewed and updated to include people's consent to care and treatment.

The manager told us the staff training matrix had been reviewed to identify each staff member's training needs. Letters were then sent to staff members advising them what training they were required to complete and by when. We saw notices on the staff notice board advising staff of the dates of face-to-face training and of the seven mandatory e-learning courses they were required to complete before 31 May 2016.

Training had been discussed during the February 2016 staff meeting. Staff were advised they would receive letters outlining the training they needed to complete. Staff were also advised failure to complete this training would result in them being prevented from attending work.

Staff we spoke to were aware of the training they were required to complete and said they felt supported and able to complete this. Cover had been arranged so that staff members were able to attend face-to-face training sessions on days when they were scheduled to be working.

We found improvements had been made with regard to the supervision and appraisal of workers. The provider's policy for supporting staff included a commitment to providing a minimum of six supervisions and an annual performance appraisal each year.

We spoke with staff about supervision and annual appraisals. They told us they had either received supervision recently, or had one coming up shortly. Staff told us they felt able to speak to senior staff, the deputy or manager about issues and that they felt supported by them. One staff member told us, "I can speak to the manager at any time; they deal with things straight away and don't brush things under the carpet." We looked at supervision and appraisal records and saw that some staff had not had regular supervision in line with the provider's policy in 2015, but that some now had records of a recent supervision. Some staff did not have a supervision recorded for 2016 and we discussed this with the manager. They told us they had met with all staff but that these sessions had not been recorded and a supervision schedule was now in place for all staff to receive formal, recorded supervisions. We reviewed the schedule and saw that dates had been set for supervisions to take place. We also found that staff had annual appraisals recorded for 2015 and that there were plans for all staff to receive an appraisal using their revised procedure by September 2016.

We looked at care records to check if people, or their representatives, had given consent to their care plans. In three of the records we looked at we saw consent had not been sought to revised or updated care plans, and the records did not always demonstrate that people, or their representatives, had been involved in any reviews of care plans. One person had a relative who held a lasting power of attorney (a legal tool that allows the person or the courts to appoint someone to make certain decisions on a person's behalf). This relative had not been consulted and another relative had signed a DNACPR which they did not have the legal authority to do. (The purpose of a DNACPR decision is to provide immediate guidance about whether a person wishes to be resuscitated or not). We highlighted this to the deputy manager to follow up and rectify.

We spoke to the manager who confirmed all care plans had recently been reviewed and as part of this process people or their representatives had been consulted. Although the care plans we reviewed had recently been updated we were not always able to find evidence that people or their representatives had been involved in this process. We highlighted this to the manager.

There was evidence of decision specific mental capacity assessments in some of the care records we reviewed. For example, one care record contained a best interest decision around the flu vaccination being given where a person had been found to lack the capacity to make this decision.

The minutes from the April 2016 staff meeting showed staff had been reminded of the importance of asking people for their consent before providing care and treatment, stating 'We ask individual consent before we proceed to carry out any care'. Staff were also reminded of the importance of recording consent in the daily notes of people's care. Although the records around consent to care and treatment were limited, during the inspection we observed staff asking people for their consent before providing care.

People we spoke with told us they felt the care they received was effective. One person told us, "I was unwell over Christmas and the staff got the doctor out and kept my family informed about how I was doing." Another person told us, "I only have to ask and the carers will sort something out for me."

We concluded that although care plans had been reviewed and updated there was not always evidence people or their representatives had been consulted as part of this process. We also found people's care records did not always contain signed consent to care and treatment records.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service caring?

Our findings

Concerns were raised with CQC that people using the service were being made to get up and go to bed early for the convenience of staff. We followed up on these concerns during this inspection.

We found some of the care plans we viewed contained specific information about when people preferred to get up or go to bed. The people we spoke with all confirmed they were able to go to bed when they wished, and could get up when they wished. One person we spoke with told us, "I have to go to bed after lunch as I cannot stay in a chair all day, but I don't sleep then." When we asked them about when they went to sleep they told us, "I often go to bed early, and watch television. But the staff check in on me and bring me a hot drink before I go to sleep." We observed on our arrival at 8am that although some people were awake and sitting in communal areas, other people were still in bed.

Staff were able to tell us about people's preferences around getting up and going to bed. One staff member told us the time people got up on a morning or went to bed on a night depended on the person and that their preferences were respected. We also found where people had a particular preference this had been reviewed in line with other areas of their care and treatment. For example one person using the service who had a preference for getting up early was prescribed time specific medicines for Parkinson's. Staff told us and records confirmed this person was supported to take their medicines before the formal medication round to enable them to get up when they wished.

When reviewing the February 2016 staff meeting minutes we found concerns had been raised by staff that people using the service were being made to get up early for the convenience of staff. The minutes showed the manager had stated this was not acceptable and had confirmed it was people's choice when they decided to get up or go to bed.

From our observations and discussions with people using the service and staff we found people were able to get up and go to bed when they wanted. We found where people had a preference for going to bed early or rising late this was respected and consideration was given to whether this had an impact on any other areas of their care, for example medicines.

We observed staff were caring when supporting people. We observed staff supporting people after a meal. Offering them choices about what they would like to do next. One person was moving about the corridor without purpose and a staff member spoke with them and supported them to find their room as they wished to lie down. We saw the staff member checked on the person later and they spoke for some time. We observed a person being supported with a meal in their bedroom. We saw the staff member interacting in a positive way with the person. They discussed their families and what had been happening that morning in the service.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in October 2015 breaches of legal requirements were found. Suitable arrangements were not in place to ensure people received person centred care and for acting on complaints.

We reviewed the action plan the provider sent to us following our comprehensive inspection. This gave assurances that improvements would be made to people's care records to capture their social and spiritual needs. It also gave assurances improvements would be made to the process for receiving and acting on complaints.

The manager advised care plans were being reviewed and we saw evidence of this in the care records we reviewed. We looked at people's care plans where they had care needs around social isolation or had specific cultural or spiritual needs. We saw one person had been identified as at risk of social isolation as they did not participate in any activities and spent most of their time in their bedroom. From their care plan we could see staff were directed to encourage the person to eat in the dining area and remind them of the activities taking place in the home. We spoke to staff about this and they told us some progress had been made. The person was now eating most meals in the dining area and whilst not participating in activities, would often observe them and remain in the communal areas. This was confirmed by our observations.

One person who had an advanced dementia related condition had specific cultural needs which included support around dress and diet. Their care plan gave specific instructions to staff about how best to support them to ensure these needs were supported consistently. We spoke with care and kitchen staff who told us about how they supported the person and this was consistent with their care plan.

We found some improvements had been made to the process for responding to complaints. We reviewed the complaints log and found two complaints had been made during 2016. There was evidence that both of these had been investigated and responded to professionally and in good detail. Although some documentation for one of the complaints was not available within the complaints log, the manager was able to explain why this was and locate the relevant documents.

The manager updated the 'service user guide' during the course of the inspection. We reviewed this and found additional information had been added informing people about how to complain, who to and how complaints could be escalated if people were not happy with the outcome they received. The manager also advised they would be adding additional contact information to the guide following the inspection.

We concluded that people's social and spiritual needs were being captured and care plans had been put in place to guide staff on how to assist people in meeting these needs. We concluded complaints were being responded to professionally and in detail and clear records were being retained.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in October 2015 breaches of legal requirements were found. Suitable arrangements were not in place to assess, monitor and improve the quality and safety of the service.

We reviewed the action plan the provider sent to us following our comprehensive inspection. This gave assurances that improvements would be made to the process for assessing, monitoring and improving the quality and safety of the service.

We found improvements had been made with the arrangements for assessing, monitoring and improving the quality and safety of the service. The service had a range of quality monitoring systems in place. Audits were completed both internally and externally. Areas for improvement identified during audits were added to the service improvement plan. The manager updated this plan on a fortnightly basis and uploaded it onto a shared drive so the regional manager could track progress. The service improvement plan could then be monitored by the regional manager. We found areas for improvement from a recent medicines audit had been incorporated into the service improvement plan and resolved.

We concluded the service improvement plan was being used effectively by the manager to capture and resolve areas for improvement identified in all audits completed.

We spoke to people and staff about the new manager and received positive feedback. One person told us, "The new manager seems nice. I often see her about the place and she speaks to everyone."

Staff told us, "It's good that we have a new manager who's staying. Some of the old problems have been resolved and we can speak our minds about anything we don't think works." Another told us, "[Name] is approachable and listens to what I have to say. I think they have made some improvements."

The manager confirmed they had applied for their registration and were aware of the responsibilities for meeting the requirement in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We discussed statutory notifications with the manager. We confirmed any safeguarding incidents, which included those where advice had been sought from the local authority safeguarding team should be notified to CQC. The manager confirmed they were aware of this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not obtained the consent of people to their care and treatment. Regulation 11 (1)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use the service were not protected against the risks associated with unsafe management of medicines. Regulation 12 (2)(g)