Enhanced Elderly Care Limited

Enhanced Elderly Care Service - Byker Hall Care Home

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?	**Good**

Summary of findings

Overall summary

This was an unannounced inspection which we carried out on 21 April 2016. We inspected the service to follow up on the breaches and to carry out a comprehensive inspection.

We last inspected Byker Hall Care Home in January 2015. At that inspection we found the service was in breach of the legal requirements in force at the time with regard to Regulation 20 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2010. This was because records did not accurately reflect people's care and support needs.

The home provides nursing care and support for up to 95 older people, some of whom live with dementia or a dementia related condition.

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

People said they felt safe. We had concerns however that there were not enough staff on duty to provide timely and individual care to people. Care was provided with kindness and people's privacy and dignity were respected. However, we saw staff were busy and did not always have time to interact and talk with people except when they were carrying out care tasks.

Staff received training and supervision. However, as the home provided care and support to a number of people who lived with severe dementia and associated mental health conditions we considered some of the nursing staff needed a background in mental health and dementia care. This was to ensure people's specialist needs were met and to complement the general nursing care that was provided. We have made a recommendation about staff training on the subject of dementia.

Staff had received training and had an understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. We have made a recommendation about medicines management where medicines were given in a person's best interest. People received their medicines in a safe and timely way.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Menus were varied and a choice was offered at each mealtime. Staff supported people who required help to eat and drink and special diets were catered for. Some activities were available for people and the activities

and entertainment programme was to be developed to ensure it met people's interests.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. People had the opportunity to give their views about the service. There was regular consultation with people or family members and their views were used to improve the service. The provider undertook a range of audits to check on the quality of care provided.

The environment was well-maintained and a programme of refurbishment was taking place as the service expanded. The environment was not yet equipped to meet the needs of people who lived with dementia. This would help people remain orientated and be aware of the environment they lived in and help people to retain some independence. We have made a recommendation about the service following best practice for equipping the environment for people who live with dementia.

Communication was effective, ensuring people, their relatives and other relevant agencies were kept up to date about any changes in people's care and support needs and the running of the service.

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

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

Not all aspects of the service were safe.

People told us they felt safe. However staffing levels were not sufficient to ensure people were looked after in a safe and timely way.

Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

People received their medicines in a safe manner.

Checks were carried out regularly to ensure the building was safe and fit for purpose.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were supported to carry out their role and they received the training they needed. We considered nursing staff should be available with a background in mental health and dementia care to ensure the specialist needs of people were met. We have made a recommendation about staff training on the subject of dementia.

Best interest decisions were not always made appropriately on behalf of people, when they were unable to give consent to their care and treatment. We have made a recommendation about the management of medicines and best interest decision making.

Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care. Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received a varied and balanced diet to meet their nutritional needs.

The environment was well-maintained and plans were being

developed to ensure the building was equipped to meet the needs of people who lived with dementia. We have made a recommendation about the service following best practice for equipping the environment for people who live with dementia.

Is the service caring?

Good

The service was caring.

Staff were caring and respectful. People and their relatives said the staff team were kind and patient as they provided care and support.

Staff were aware of people's backgrounds and personalities. This helped staff provide individualised care to the person. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

People were encouraged and supported to be involved in daily decision making.

Is the service responsive?

Good

The service was responsive.

Improvements had been made to record keeping. This meant people received support in the way they wanted and needed because staff had detailed guidance about how to deliver their care.

People were provided with some activities and the programme was being expanded and developed to become more person centred with the recruitment of an additional activities person. People had the opportunity to access the local community.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A manager was in place who was becoming registered with the Care Quality Commission. Staff and relatives told us the manager was supportive and could be approached for advice and information.

The home had a quality assurance programme to check on the

quality of care provided.

Improvements were being made by the manager and management team to promote the delivery of more person centred care for people.

Enhanced Elderly Care Service - Byker Hall Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 April 2016 and was unannounced. The inspection team consisted of an adult social care inspector, an expert by experience and a specialist nursing advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people. The specialist advisor helped us to gather evidence about the quality of nursing care provided.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams. We also contacted health and social care professionals who worked with the service. We received no current information of concern from these agencies.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with nine people who lived at Byker Hall, two relatives, the manager, the director of care, three registered nurses, one unit manager, nine support workers, the activities organiser and two members of catering staff. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care records for eight people, recruitment, training and induction records for five staff, eight people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the manager had completed.

Requires Improvement

Is the service safe?

Our findings

We had concerns there were insufficient numbers of staff available to keep people safe although some people had commented that they felt safe. Due to some people's complex needs we were not able to gather their views. Other people said they felt safe and they could speak to staff. Peoples' comments included, "The home is lovely and the staff are very good, but they do need more staff," "It's like home, there's always someone around if I need help," "I feel absolutely safe," "I do feel safe, there's always someone there if you need them," and, "I can't get a shower as often as I used to." Relatives' comments included, "I know [Name] is safe when I go home," and, "I looked at 30 homes before I chose this one, I would recommend it to anyone looking for care."

Since the last inspection the home had expanded and could now accommodate up to 95 people as building work had taken place to amalgamate two separate buildings. There were 56 people who were living at the home at the time of inspection. The home was divided into two wings, North and South. South accommodated 31 people who lived with more severe dementia related needs and nursing care needs and North accommodated 25 people some who lived with dementia but who did not require nursing care. We were told that usually there were eight support staff available on the South unit but a staff member was absent and they were not replaced until the afternoon. We had concerns there were insufficient staff to care for people on the South unit in a safe, consistent and timely way.

During the inspection we observed South unit was very busy. Staff across the unit were very busy and care was task centred and not person centred as staff did not have time to interact with people except when they carried out care. We were told people sometimes did not have the opportunity to get up when they wanted One person told us at 10:30am, "I'm uncomfortable in bed, and I'm waiting for staff to come and help me wash and dress. It varies from day to day what time staff arrive to help me." We were told 13 of the 14 people on the top floor required two members of staff to safely move and support them. Six of the people were confined to bed and staff provided care such as regular re-positioning people in bed because of their support requirements. A number of people who lived with severe dementia needed full staff support for all their needs. Some people displayed distressed behaviour and their care plans stated they needed reassurance and supervision from two or three members of staff because of their anxiety. This meant whilst one person was assisted by two staff other people had to wait for help as only one member of support staff was available to provide supervision and support. On the ground floor we were told 14 of the 17 people accommodated on this floor also required two members of staff for their care and support needs. Some of the people's care records also showed they required three members of staff for their care and support needs. We observed people on this floor also had to wait some time for assistance as staff were so busy. This meant staffing levels were not sufficient to assist people in a timely way and to provide person centred care. The nurse on each floor was not available to provide direct care and support as they had other duties to carry out to ensure people's health care needs were met.

There was considerable movement around the South Unit due to staff being deployed to assist between the two floors which left that unit short staffed when the staff member went to assist on the other floor. A person commented, "There are lots of different care workers, but you don't get a chance to know them." In the

afternoon staffing levels were further reduced to two support workers on the top floor when a staff member escorted a person to a hospital appointment. Buzzers rang repeatedly throughout the day and response times were varied as staff were busy. It was also noted the nursing staff moved frequently across the floors on various tasks despite a nurse being allocated to the two floors on the South nursing unit. It was also noted nurses on the South unit had to leave the unit on several occasions and go to other areas of the home as faxing equipment was not available on the unit in order to fax prescriptions to the pharmacist. This was so people would receive their newly prescribed medicines promptly. However, this meant a nurse was not always accessible and available if someone required urgent nursing assistance on the unit. A staff member commented, "There's no time during the day to think sometimes, you go on all the time."

Our observations at the lunch time meal on the South unit did not show that sufficient staff were available to supervise people and ensure they received their meal. On the ground floor three staff were available to serve and support 10 people who sat in the dining room for their meal. Three of these people needed assistance to eat their food and some other people required prompting. Four people who remained in their bedrooms also required assistance to eat their meal. As staff were busy it was 30 minutes before it was noticed that a person had not received their meal. On the ground floor people also had to wait at the table after their lunch time meal for some time as staff were busy with other people

The North unit accommodated 25 people who were supported by four support workers including a senior support worker to each floor. Two support workers were available for each floor on the unit and some people on each floor required two members of staff for their moving and assisting needs. This meant when the two staff were busy with people in the lavatory and bedrooms other people had to wait and were left unattended.

Overnight staffing levels included from 8.00pm until 8.00am one nurse and eight support workers for the home. We considered one nurse to attend to 31 people's clinical needs and to manage the home overnight was insufficient and should be increased to ensure people's needs were met safely. The numbers of support staff on duty at night should also be kept under review as occupancy levels increase and people's support needs change.

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

The manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged appropriately by the manager. 12 safeguarding alerts had been raised since the last inspection. They had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns. The information had been shared with other agencies for example, the local authority safeguarding team. One safeguarding alert raised by another agency was under investigation by the local authority safeguarding team at the time of inspection.

Staff had an understanding of safeguarding and knew how to report any concerns. They were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. They told us they would report any concerns to the registered manager. One support worker told us, "I'd go straight to the nurse if I was worried and had any concerns." Nursing staff spoken with showed a good understanding of peoples' individual needs and their vulnerabilities, and the need to provide a safe environment. They said they regularly reminded care staff of

the safeguarding process.

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the department of psychiatry of old age and the community mental health team. Staff told us they followed the instructions and guidance of the community mental health team for example to complete behavioural charts if a person displayed distressed behaviour. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known.

Medicines were given as prescribed. We observed a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Systems were in place to ensure that all medicines had been ordered, administered safely and audited. Medicines were stored securely within the medicines trollies and treatment room. However, it was apparent the treatment room was very warm. Records showed temperatures were recorded daily. The initial temperature on the day of inspection was recorded as 26 degrees centigrade and despite a window being opened to reduce the temperature a second reading later in the day recorded 29 degrees centigrade. This was above the recommended temperature of no more than 23 degrees as advised by the British Pharmaceutical Society for the storage of medicines. When we informed the manager they made immediate arrangements for a portable air condition unit to be installed.

Medicines which required cool storage were kept in a fridge within the locked treatment room. Records showed current temperatures relating to refrigeration were recorded daily and were within the required range for the storage of refrigerated medicines. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and to keep people safe. They included risks specific to the person such as for falls, pressure area care and nutrition. Records contained information for staff on how to reduce identified risks, whilst avoiding undue restrictions. For example, a falls risk assessment included measures to minimise the risk of falls.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. It also included their mental capacity to understand. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS), which

checks if people have any criminal convictions, had been obtained before applicants were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Requires Improvement

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs and they were supported in their role. Staff comments included, "We do get training," "There is always training going on," "I welcome any training," "I'm doing a National Vocational Qualification (NVQ) at level 3 (now known as the diploma in health and social care)," and, "There's lots of training." Staff members were able to describe their role and responsibilities. Some staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. One staff member told us, "I had a two day induction." The Provider Information Return (PIR) submitted by the manager before the inspection stated new staff members would have the opportunity to study for the Care Certificate in health and social care as part of their induction training.

The staff training records showed staff were kept up-to-date with safe working practices. The manager told us there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Staff training courses included, medicines management, person centred care, nutrition and malnutrition, dignity awareness, mental capacity, deprivation of liberty safeguards, person centred care, distressed behaviour and equality and diversity. 35 support staff had obtained a National Vocational Qualifications (NVQ).We were told future planned training included end of life care, wound care and more in depth dementia care training.

We observed the new unit accommodated people with some complex mental health needs associated with dementia. We discussed with the manager that care could be enhanced to people with mental health conditions, including people who lived with dementia, by ensuring some nursing staff had a background and clinical competencies in mental health and care of people who lived with dementia. This would complement the nursing staff currently in place who had registered general nursing or registered nurse learning disability status. This would supply leadership and guidance for staff as the majority of needs of people who lived at the home related to dementia or dementia related conditions. It would also give staff more insight into the management and understanding of distressed behaviours. We were told a registered nurse who was a unit manager was interested in becoming a registered mental health nurse. Feedback from some healthcare professionals who we contacted as part of the inspection also indicated that some staff had limited understanding of people who lived with severe dementia. Their comments included, "Initially I did have difficulty with levels of engagement from staff however, with a joint multi-disciplinary team effort we were able to work collaboratively with the manager to achieve positive results for a person," and, "Some staff previously had limited understanding of dementia and challenging behaviour as they had thought some people's behaviours were attention seeking. However, staff understanding and awareness had improved for some people through education and staff had taken on board suggestions for improvement."

We recommend the service considers further training about dementia care and ensuring the nursing staff skill mix includes staff with a registered mental health nursing status.

People were supported to maintain their healthcare needs. People's care records showed they had regular

input from a range of health professionals such as, General Practitioners (GPs), psychiatrists, a speech and language team (SALT) and dietician. Records were kept of visits. Care plans reflected the advice and guidance provided by external professionals. Health care professionals we asked commented about care provided by staff. Their comments included, "I have found staff to be welcoming and I have developed good working relationships with them. Staff regularly ask me for help and advice regarding people's care. If there have been concerns re aspects of care I have spoken with the manager and looked at ways of improving care. Sometimes this has involved slight changes in paperwork, and other times education has been delivered by myself and colleagues to make improvements." They told us people were referred straight away if there were any concerns about their health. We were told staff usually followed their advice and guidance.

We were told by a health care professional we contacted before the inspection that a weekly clinic took place at the home. The clinic was run by the General Practitioner from a local surgery, a specialist nurse and supported by a nurse from the home. The clinic was held to review people's health needs and their medicines and make sure they were treated promptly. It was also to help prevent people's unnecessary admission to hospital. We were told relatives also had the opportunity to attend the clinic to support their relative.

At the last inspection we had concerns communication was not effective to ensure people's needs were met. At this inspection staff told us communication was much more effective. Staff members' comments included, "Communication is much better," "We work as team," "Communication is brilliant," "There's good rapport with senior staff," and, "Communication has improved." We were told a handover session took place, to discuss people's needs when staff changed duty, at the beginning and end of each shift. We observed one hand over on the South unit and listened to the formal verbal exchange of information that took place about the people. This was to ensure staff were aware of the current state of health and well-being of the person. It was done in a detailed and professional manner and included any key tasks that needed to be undertaken. We saw handover records contained information about the care provision and the state of well-being for each person over the previous 12 hours. Written information was also referred to with regard to any concerns with people's dietary needs and any personal care issues. The manager was involved and supplied with copies of the daily handover of information. Staff told us the diary and communication book also provided them with information. Relatives we spoke with told us they thought communication was good and they were kept informed by the staff about their family member's health and the care they received

Staff were supported in their role. Staff told us and their training files showed they received regular supervision from the management team, to discuss their work performance and training needs. Support staff said they received regular supervision from one of the home's management team every three months and nurses received supervision from the registered manager. Staff comments included, "The nurses are supervised by the manager," and, "Nurses supervise the support staff." Staff also received an annual appraisal to evaluate their work performance and to jointly identify any personal development and training needs.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

Records contained information about people's mental health and the correct 'best interest' decision making process, as required by the Mental Capacity Act 2005. Best interest decision making is required to make sure

people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes. Peoples' care records showed when 'best interest' decisions may need to be made. Example from care plans included, "I can answer simple questions but am finding difficulties, wandering in and out of different circumstances," "All staff to be made aware of [Name]'s dietary needs due to [Name]'s memory loss, as they have a right to remain a vegetarian at their wish," and, "[Name] continues to require 'best interest' decisions regarding their health care and wellbeing due to being unable to retain information."

People were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'. For example, a care plan for a person who required the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink) stated, "A 'best interest' decision has been put in place to ensure that [Name]'s medicines are given to alleviate the pain and feelings of depression." We saw although a letter was available from the General Practitioner advising the use of covert medicine the 'best interest' decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines. A 'best interest' meeting had not taken place involving the relevant people. NICE guidelines state, "A 'best interest' meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests." The manager told us that this would be addressed.

We recommend the service considers the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes with regard to the use of 'covert medicine.'

Staff asked people for permission before delivering any support. They said they would respect the person's right to refuse care. Staff said if a person did refuse they would offer alternatives or leave the person and try again later. For example, if a person refused their medicine.

People can only be deprived of their liberty so that they can 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. Staff were aware of and had received training in the MCA and the related Deprivation of Liberty Safeguards (DoLS). They had a good understanding of the MCA and best interest decision making, when people were unable to make decisions themselves. The manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. The manager told us 36 applications had been authorised, two other applications were being processed and other applications were in the process of being completed for people.

Systems were in place to ensure people received drinks and varied meals at regular times. We looked around the kitchen and saw it was stocked with fresh, frozen and tinned produce. We spoke with the chef who was aware of people's different nutritional needs and special diets were catered for. They explained how people who needed to increase weight and to be strengthened would be offered a fortified diet and how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. The chef told us they received information from nursing staff when people required a specialised diet. For example, diabetic, vegetarian and soft or pureed diets. We saw a white board was available in the kitchen and we were told it was completed to inform the cook of the dietary preferences and specialised diets for people. However, it

was blank and we advised the cook the information could be displayed without breaching people's confidentiality if initials were used. This meant information about people's nutritional needs would be readily available for catering staff when the regular cook was not on duty.

Meals looked appetising and were well presented and people told us they had a choice at meal times. Peoples' comments included, "I'm well-fed," "There's always a second helping available ," "The food here is lovely," "Staff make sure I get a choice, I've been a vegetarian since the war," "The food is good and we do get a choice," and, "I get asked what I'd like to eat."

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Information from people's nutritional assessments were transferred to a care plans where necessary. For example, one person's care plan advised, "[Name] is at risk of weight loss and their food and fluid intake to be monitored daily and weight to be monitored reporting any loss of more than 2.5kg to the General Practitioner (GP)." Staff completed daily monitoring charts to record the food and fluid intake of some people who were assessed at being at risk of weight loss. However, we noted the food charts did not accurately record the person's nutritional intake as they did not refer to the amount consumed by the person at each meal but relied upon staff's interpretation of the amount eaten. The manager told us that this this would be addressed. Nutritional care plans also recorded people's food likes and dislikes and any support required to help them eat. For example, "[Name] likes finger foods such as biscuits, sandwiches, chocolate, grapes and bananas and likes to drink tea," and, "[Name] is a vegetarian and can eat and drink independently."

The building was clean, bright and spacious and the North Unit was in the process of being refurbished. We noted in the newly refurbished South Unit, the environment, especially to the top floor was very sunny, warm and not well-ventilated. Some people chose to have the windows open for air but this was not mutually agreed by people in the communal areas where it was the hottest, because other people wanted them closed. We requested portable fans as an interim measure to be put in place on the top floor to help reduce the temperature. The South Unit was well-decorated and we saw plans were recorded in the Provider Information Return to ensure the building was equipped with appropriate signage to assist in the orientation of people. Doors such as lavatories, bedrooms and bathrooms were to have pictures and signs for people to identify the room to help maintain their independence. This and other aids for orientation would help some people who lived with dementia to remain orientated and be aware of their surroundings.

We recommend the service considers the latest guidance for the appropriate environmental design in care homes to assist the orientation and independence of people who live with dementia.

Good

Is the service caring?

Our findings

People who could comment were positive about the care and support provided. Their comments included, "The care is excellent," "The staff are very helpful, "Lovely people, nice place," "Everything is fine," "Staff are fantastic," "Some of the carers are really lovely, I miss the lovely ones when they are on their days off," "The carers are ok, some are good and some not so good and some are lovely," and, "The care staff are respectful to me." Relatives' comments included, "Staff are very caring and I'm happy that they're getting to know [Name] better," and, "The staff are very caring." A health care professional commented, "The staff I have met with have all been warm, welcoming, friendly, professional and approachable. I have observed different staff engaging well with people and it seems they develop good relationships with people. Residents I have worked with have spoken positively about the home's staff. "

During the inspection there was a relaxed and pleasant atmosphere on the North Unit of the home. The South Unit was not relaxed and calm as people were waiting for staff assistance. Throughout the home staff interacted well with people. They were warm, kind, caring and respectful with people and most people appeared comfortable with them. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance with a gentle touch on the arm. They explained what they were doing as they assisted people and they met their needs in a sensitive and compassionate manner, for example, as they hoisted a person because of their moving and assisting needs. Staff although busy were patient in their interactions and took time to observe people's verbal and non-verbal communication. We observed staff interact sensitively with a person who required a lot of attention and reassurance during the afternoon.

People's privacy was respected. Staff knocked on people's doors before entering their rooms, including those who had open doors. Most people sat in communal areas but some preferred to stay in their own room. Staff treated people with dignity and respect. We observed that as people were hoisted a blanket was used as they sat in the hoist to maintain their dignity as they were transferred. We saw staff observed and offered any prompts and words of encouragement to people at meal times to provide assistance. They also checked that people had enjoyed their meal. Staff meeting minutes also showed people's dignity was promoted. Meeting minutes recorded that male and female staff should be available on night duty to respect the wishes of people and their choice of gender of carer to assist with their care and support.

We saw people who lived with dementia were encouraged to make a choice and be involved in decision making. For example, with regard to meals, drinks and other activities of daily living. A care plan for communication stated, "All interventions need to be explained by showing [Name] and talking them through it step by step." Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. One person's care plan recorded, "[Name] can choose their own clothing for the day and guidance to be given for matching items." Staff told us they also observed facial expressions and looked for signs of discomfort when

people were unable to say for example, if they were in pain.

Information was available for people to keep them informed and to help them make choices. For example, menus were available in written and photographic format to keep people informed and help them make a choice of food. However, we considered information about activities could be made more accessible to people as there were several smaller notices around the home that advertised the activities that were available but they were not available in large print or pictorial format for people who no longer recognised the written word.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision themselves. For example, an emergency health care plan was in place for a person. The care plan detailed the "do not attempt resuscitation" (DNAR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met. A care plan for a person who was not receiving end of life care stated, "[Name] to be cared for at Byker Hall unless a relative and General Practitioner think in their 'best interest' a hospital admission is required."

We were told the service used advocates as required and three people were supported by Independent Mental Health Care Advocates (IMHCA) because they lacked the mental capacity to make decisions with regard to their well-being. Advocates can represent the views for people who are not able to express their wishes. Information was displayed that advertised what advocacy was and how the service could be accessed.

We observed the lunch time meal over the different units of the home. The atmosphere was busy on the South Unit and staff were stretched however they tried to ensure people received a pleasurable dining experience. Staff were seated with people who required support and interacted with them individually. Staff provided full assistance or prompts to people to encourage them to eat. For example, we heard a staff member ask a person, "Shall I cut that for you," and, "Would you like some more chips." Staff spoke with people in a quiet, gentle way and explained to people what they were getting to eat with each spoonful. Staff talked to people as they helped them and as lunch was served. People sat at tables set with tablecloths, napkins and flowers. Specialist equipment such as adapted cutlery and plate guards were available to help people. People sat at tables set for three or four. Some people ate in their rooms and we observed food was covered as they transported it to people's bedrooms. Staff addressed people by their preferred name or title. Staff did not assume people's preferences and offered people a choice of food verbally or showed two plates of food that contained the two options. For example, we heard a staff member ask a person, "Would you like chicken or corned beef," as they showed them the two plates of food. Portion size was also varied according to people's needs.

Good

Is the service responsive?

Our findings

At the last inspection we had concerns that records did not accurately reflect people's care and support needs for staff to provide the correct care and support to people in the way the person wanted and needed. We saw that improvements had been made to ensure that records accurately reflected peoples' care and support needs.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. For example, with regard to nutrition, communication, pressure area care, mobility and falls and personal hygiene. Evaluations were more detailed and included information about peoples' progress and well-being. A care plan for the management of catheter care was exemplary in its detail. The unit manager told us new care plan documentation had been introduced which allowed for more detail. This helped to ensure staff had information and guidance about people's care and support needs which also detailed how their care was to be delivered.

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in peoples' needs. For example, the behavioural team were asked for advice with regard to people's distressed behaviour as required. For another person who had been losing weight, records showed a referral had been made to the dietician and their weight was being monitored weekly. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly.

Charts were also completed to record any staff intervention with a person. For example, when staff turned a person in bed, where it was identified a person was at risk of developing pressure areas, when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to date needs and preferences. Care plans alerted support staff when a person may be at risk of developing pressure areas on their body. For example, one care plan for a person who did not receive nursing care recorded, "Staff to monitor skin integrity … and any signs of redness or breakdown to be reported. [Name] should also be asked if there are feelings of sickness or discomfort, the senior staff to liaise with the district nursing team or General Practitioner."

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service. Care plans were more detailed and provided information and guidance for staff about peoples' care needs and how they liked to be supported. For example, a care plan for personal hygiene stated, "[Name] is able to dress independently but can be reluctant to change their clothes, prompting is required," and, "[Name] needs assistance with buttons and zips. Care staff to prompt [Name] to brush their teeth and comb

their hair." Care plans for other needs were in place. For example, part of a care plan for mobility recorded, "[Name]'s fall risk increases when they are constipated as [Name] becomes more restless, agitated and leans over to one side." A care plan for social isolation stated, "…. staff are to try and encourage [Name] to join in with activities and socialize with others."

People's care records were up to date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. For example, "[Name] is a vegetarian," "[Name] likes fruit, vegetables and sweet things," and, "[Name] likes to drink tea with milk and no sugar."

An activities organiser was available. We were informed a second activities organiser had been appointed and was waiting for their vetting checks to be completed and then they would begin work. A programme of activities was available and these included, board games, bingo, baking, arts and crafts, games and puzzles, pamper sessions, movie afternoons, karaoke, dominos, card games and one to one shopping. We received mixed comments from people about activities. They included, "I play bingo in the afternoons, there's plenty to keep me busy," "I find it very boring, I only go out with my friends," and, "I've played bingo but there is nothing else to do." We spoke with the activities person to ensure individual as well as group activities were based around the needs of the individual incorporating people's previous interests and hobbies. The activities person told us people had the opportunity to go out on an individual basis with staff support.

Meetings were held with people who used the service and their relatives. The manager told us meetings provided feedback from people about the running of the home. Meeting minutes from February 2016 showed that people were asked for ideas about activities and outings. Relatives and people had the opportunity to select resources. A pop up sweet shop was selected as an activity to be transported around the home. We discussed with the manager the possible formation of a separate resident meeting and individual consultation with some people who used the service, depending upon people's capacity and interest. This could further improve consultation with people to gather their views about the running of the home and areas of importance such as activities and menus. We saw other areas discussed at relatives meetings included suggestions for new menus, updates on the refurbishment of the home and addressing people's concerns about staffing levels. Meeting minutes gave feedback about action taken since the previous meetings.

People said they knew how to complain. Peoples' comments included, "I am very happy here, settled in lovely with no complaints," I'd speak to the manager if I had any concerns," "I've no complaints I'm very, very happy here," and, "No complaints at all nice place and nice people." The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained and we saw one had been received and had been investigated and resolved.

Good

Is the service well-led?

Our findings

A manager was in place who was in the process of registering with the Care Quality Commission (CQC). The registered provider had been pro-active in submitting statutory notifications to the CQC, such as safeguarding notifications, applications for DoLS and serious injuries.

We found that the areas of noncompliance and areas for improvement identified at the last inspection had been rectified. The manager had made improvements to the service to benefit people who used the service. Communication had improved to ensure people's health care and support needs were met. Care records accurately reflected peoples' support needs and contained the information staff needed to safely care for people. The manager had several ideas they wished to introduce to enhance the care of people who lived with dementia. For example, the use of computer technology for people, a more enabling environment for people who lived with dementia to promote their independence, more person centred activities, outings and entertainment, the introduction of volunteers from colleges to the home including work placements for people with learning disabilities to promote community links for people who used the service. This will be of benefit to people who use the service with the creation and support of a strong staff team.

The atmosphere in the service was more relaxed on the North Unit but not on the South Unit. Staff were busy but staff said they felt well-supported by the unit managers. They said they could approach them to discuss any issues. A staff member commented, "The unit manager is approachable." Relatives told us the manager was approachable and relative meeting minutes showed the manager was responsive and took action to respond to any concerns that may be raised.

Regular analysis of incidents and accidents took place. The manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re-occurrence. For example, when a person had fallen.

Records showed audits were carried out regularly. They showed action that had been taken as a result of previous audits where deficits were identified and the follow up action that had been taken. Weekly checks included fire checks and health and safety. Monthly audits included checks on accidents and incidents, staff training and supervision, medicines management, infection control, nutrition, skin integrity, home presentation and falls and mobility. Checks were also carried out on personnel files and finances. A larger audit also took place at six monthly intervals and these included for health and safety and infection control. The manager told us two monthly visits were carried out by the director of care to speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans, complaints, accidents and incidents and staff files. We saw the report from the February 2016 visit that had been carried out by the previous Director of Operations and this included a checked on a sample of the monthly audits carried out by the home manager. The visits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

Staff told us and we saw staff meeting minutes to show staff meetings took place regularly and these included nurses meetings, night staff meetings, support worker meetings and domestic and kitchen staff

meetings. Staff meetings kept staff updated with any changes in the service and to discuss any issues. Staff members told us meeting minutes were made available for staff who were unable to attend meetings. Staff members' comments included, "We have regular meetings," and, "We had a meeting in February." Meeting minutes from January and February 2016 showed areas discussed included, "Health and safety, staffing and staff performance, night staffing, maintenance and security of the building.

The manager told us the registered provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out annually to people who used the service. Surveys had been completed by people who used the service in May 2015. We saw 22 surveys had been returned from the 65 sent out. The results had been analysed and feedback was advertised in the home showing what action was taken as a result of the survey. For example, people had stated it was difficult to make contact with the home at the weekend when the administrator was not on duty. We saw a second administrator was now available to work on the Saturday morning. People's comments from the provider survey included, "The staff are lovely, feels like home here," Byker Hall is like a small community of its own," "Staff are very caring," and, "Nurses were excellent in caring for [Name] and getting them back to health."

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured staffing levels were sufficient to provide safe and person centred care to people at all times. 18 (1)