Gainford Care Homes Limited

Lindisfarne Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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 inspection took place on 6 and 7 December 2017 and was unannounced. This meant the staff and provider did not know we would be visiting.

Lindisfarne Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Lindisfarne Care Home accommodates 61 people in one adapted building across three separate floors. Some of the people using the service were living with dementia. On the days of our inspection there were 60 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

We last inspected the service in October 2015 and rated the service as 'Good.' At this inspection we found the service remained 'Good' and met all the fundamental standards we inspected against.

Accidents and incidents were appropriately recorded and risk assessments were in place. The registered manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

Procedures were in place for the safe administration and storage of medicines. However, some as required medicines were not appropriately recorded.

The home was clean, spacious and suitable for the people who used the service. Infection control audits were carried out monthly and an overall audit conducted annually, and appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff. Staff were suitably trained and received regular supervisions and appraisals.

People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. However, some mental capacity assessments were blank or were not decision specific. Some of the consent to care and treatment records were not signed by people or their representatives.

People were supported with their dietary needs. Care records contained evidence of people being supported during visits to and from external health care specialists.

People who used the service and family members were complimentary about the standard of care at Lindisfarne Care Home.

Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

The service supported people to access local advocacy services but no-one was currently using advocacy services at the time of our inspection visit.

Care records showed that people's needs were assessed before they started using the service and care plans were written in a person-centred way. Person-centred is about ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

Care plans were in place that recorded people's plans and wishes for their end of life care.

Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs.

The provider had an effective complaints procedure in place and people who used the service and family members were aware of how to make a complaint.

The provider had an effective quality assurance process in place. Staff said they felt supported by the registered manager. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remained Good.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider was not always working within the principles of the Mental Capacity Act 2005 (MCA) as some mental capacity assessments were blank or were not decision specific. Consent to care and treatment records had not always been signed by the person or their representative.

Staff were suitably trained and received regular supervisions and appraisals.

People had access to healthcare services and received ongoing healthcare support.

Is the service caring?

Good

The service remained Good.

Is the service responsive?

Good

The service remained Good.

Is the service well-led?

Good

The service remained Good.

Lindisfarne 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 6 and 7 December 2017 and was unannounced. One adult social care inspector, a specialist advisor in nursing and an expert by experience formed the inspection team. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We also contacted Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with 11 people who used the service and eight family members or visitors. We also spoke with the registered manager, nurse, and four members of staff.

We looked at the care records of five people who used the service and observed how people were being cared for. We also looked at the personnel files for four members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People who used the service and family members we spoke with did not raise any concerns about safety at Lindisfarne Care Home. A family member told us, "There is always at least one carer present in the lounge, the residents are never left alone."

We discussed staffing levels with the registered manager and looked at staff rotas. Staffing levels varied depending on the needs of the people who used the service. Most of the comments we received regarding staffing levels at the home were positive. However, one family member told us, "I feel there should be more staff. I am here every afternoon but most residents don't have anyone to talk to, the staff don't have time." During our visit we observed sufficient numbers of staff on duty to keep people safe. We also observed staff spending time with people and interacting with them.

The provider had an effective recruitment and selection procedure in place and carried out relevant security and identification checks when they employed new staff to ensure they were suitable to work with vulnerable people. These included checks with the Disclosure and Barring Service (DBS), two written references and proof of identification. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults.

Although the lounge carpet on the second floor was stained, the home was generally clean and there were no unpleasant odours. Infection control audits were carried out monthly and an overall audit conducted annually. The audits ensured staff training was up to date, appropriate measures and equipment were in place to reduce the risk of infection, staff were aware of infection control protocols, cleaning schedules were in place and waste was appropriately disposed of. In addition, monthly checks took place of bedrooms, mattresses, domestic storage, general areas of the home and the laundry. We saw any identified issues had been actioned.

Monthly health and safety audits took place and regular checks were carried out of the premises and equipment. These included electrical testing, gas servicing, portable appliance testing (PAT), lifting equipment and hot water temperatures. Records we saw were up to date and hot water temperatures were within recommended levels.

Risks to people's safety in the event of a fire had been identified and managed. For example, a fire risk assessment was in place, fire alarm and fire equipment service checks were up to date, fire drills took place regularly and Personal Emergency Evacuation Plans (PEEPs) were in place for people.

We saw a copy of the provider's safeguarding policy and looked at the safeguarding file. This contained information from the local authority on how to deal with and report an incident of abuse or alleged abuse, a safeguarding register that was completed by the registered manager for each safeguarding record, and copies of safeguarding alerts and supporting information. We found the registered manager understood

safeguarding procedures and had followed them, statutory notifications had been submitted to CQC, staff were aware of their responsibilities and had been trained in how to protect vulnerable people.

Accidents and incidents were appropriately recorded and a monthly accident report was completed to identify any trends or further actions. Records included details of actions taken to reduce the risk, recommendations and lessons learned. For example, following one incident it was recorded that the family of the person had not been informed in a timely manner. The registered manager had recorded this as an error and we saw from later records that it was clearly recorded that family members had been informed of any accident or incident.

Risk assessments were in place for people who used the service. These described potential risks and the safeguards in place to reduce the risk. Risk assessments included the environment, wheelchairs, moving and handling, mobility, falls, use of bed rails, nutrition and hydration, choking, continence, skin integrity, and medicine administration. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

Systems were in place to ensure that medicines had been ordered, received, stored, administered and disposed of appropriately. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed.

Medicines were given from the container they were supplied in and we observed staff explain to people what medicine they were taking and why. People were given the support and time they needed when taking their medicines. People were offered a drink of water and staff checked that all medicines were taken. People's medicine individual support needs were recorded in their care records.

The medication administration records (MAR) we viewed showed staff recorded when people received their medicines and entries had been initialled by staff to show they had been administered. A MAR is a document showing the medicines a person has been prescribed and records when they have been administered.

One person's medicines were crushed and administered via a feeding tube. There was written authorisation from the person's GP with regard to this and a best interests meeting had been held between the GP, nurse and the person's relative regarding administering their medicine in this way.

Protocols were in place for PRN, or as required medicines. PRN protocols assist staff by providing clear guidance on when PRN medicines should be administered and provide clear evidence of how often people require additional medicines such as for pain relief. However, some people's PRN medicines had not been recorded on their MAR. This meant there was no mechanism in place for recording the administration of these PRN medicines. We informed the nurse of this who agreed to check all the records and discuss it with the pharmacist.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. Staff were aware of the required procedures for managing controlled drugs.

Medicine storage temperatures were recorded, however, there had been some inconsistencies in the recording of the temperature of one of the refrigerators during the previous month. The registered manager was aware of this and had identified a problem with the thermometer. A new thermometer had been purchased and temperatures were now being appropriately recorded.

Requires Improvement

Is the service effective?

Our findings

People who used the service told us they received effective care and support from well trained and well supported staff. A person told us, "It's really lovely in here." A family member told us, "I am very pleased with the care towards my [relative]. I only had to go to the manager once about my [relative]'s eating. It was sorted straight away and she let me know what was happening." Another family member told us, "I am very pleased with the care my [relative] receives. The nurses are very good. A couple of times they needed to call out the community matron. They were quick with no problems or issues. The office or manager call me if they have any problems."

People's care records contained a pre-admission assessment to assess their needs before they moved into the home. This ensured that staff could meet people's needs and that the home had the necessary equipment to ensure the person's safety and comfort.

Some people were at risk of malnutrition and received support with their dietary needs. The malnutrition universal screening tool (MUST) was used to complete individual risk assessments in relation to assessing the risk of malnutrition and dehydration. This helped identify the level of risk and appropriate preventative measures. Risk assessments were in place for people identified as being at risk of diabetes. Support plans and blood monitoring charts were in place and included guidance provided by the person's GP on monitoring and documenting blood sugar levels to ensure they were stable.

Staff monitored some people's food and fluid intake to minimise the risk of malnutrition or dehydration. Food charts recorded the food a person was taking each day and included portion sizes. Fluid intake charts recorded the fluid a person was taking each day. All charts were fully completed, which showed staff were effectively monitoring people's intake and taking action as required.

Food surveys were carried out every six months to gauge people's views on the quality of the meals served at the home. Where any comments or complaints had been received, we saw these had been actioned and the kitchen staff had been made aware.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager understood their responsibilities with regard to the DoLS. They maintained a DoLS file and log that recorded when DoLS had been applied for, when they had been authorised, expiry date and

any additional comments. Where people lacked capacity to make decisions, mental capacity assessments and best interest decision meetings had taken place and were recorded. However, for some people their records were blank or were not decision specific. For example, one person's mental capacity assessment described that due to their deteriorating health they could not make their own decisions, however, this was not decision specific and there was no record of a best interest decision being made. We discussed this with the registered manager who agreed to action this.

Some of the consent to care and treatment records we looked at were not signed by people where they were able. If they were unable to sign we did not see that a relative or representative had signed for them. The registered manager told us they would action this.

Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records we saw were up to date and showed the person who used the service had been involved in the decision making process.

Care records contained evidence of visits to and from external specialists including GPs, nurse practitioners, continuing health care nurses and dentists.

Staff were supported in their role and received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace.

Compliance with mandatory training was monitored by the registered manager via an electronic training matrix. Mandatory training is training that the provider deems necessary to support people safely. Staff mandatory training was up to date and where it was due, refresher training was planned. New staff completed an induction and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care. A staff member told us, "I love it here, there is plenty of different training. In my last job we had no training."

Some of the people who used the service were living with dementia. The service had incorporated dementia friendly décor into the design of the premises. For example, carpets were clean, not patterned and contrasted clearly with walls. Likewise, hand rails contrasted with the walls and communal spaces and bathrooms were spacious and free from clutter. There was visual stimulation on the walls, including photographs of old movie and music stars. A small 'Reminiscence room' was available on the first floor and contained old newspapers and magazines, books, old furniture and ornaments. We saw staff go into the room to take out magazines for people to look at.

Good

Is the service caring?

Our findings

People we saw were well presented and looked comfortable in the presence of staff. Staff treated people with dignity and respect. We saw staff knocking on bedroom doors and asking permission before entering people's rooms.

People were assisted by staff in a patient and friendly way and we saw and heard how people had a good rapport with staff. For example, we observed staff spending time with people in one of the lounges. People were talking and laughing with staff and we observed one staff member holding a person's hand while they spoke with them.

Care records described how people were supported to be independent and care for themselves where possible. For example, "[Name] can manage to be independent with personal cleaning and dressing but needs instructions and prompts from staff", "[Name] is capable and independently able to wash their hands after using the toilet or before eating but needs prompts from staff" and "[Name] is independently mobile."

People's preferences were clearly documented in their care records. For example, one person was described as being a "smart lady" and was able to make choices about what clothes they preferred to wear each day. People's bed time and preferred time for rising in the morning were recorded.

Communication care plans were in place and were appropriate for the person. We saw specific information for staff to follow in relation to how they engaged with people. This approach meant staff provided responsive care, recognising that people living with communication needs could still be engaged in decision making and interaction. For example, "Staff to reassure [name] when they are anxious calling for relative, their house, their keys. Staff to make sure their glasses are cleaned at least daily" and "[Name]'s communication skills have declined, they are now very forgetful and repetitive and also signs of confusion are evident. When speaking to [name] staff to speak clearly and slowly allowing them time to absorb the information."

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring the confidentiality of people's personal information as it could only be viewed by those who were authorised to look at records.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. We discussed advocacy with the registered manager who told us none of the people using the service at the time of our inspection had independent advocates.

Good

Is the service responsive?

Our findings

Care records we looked at were regularly reviewed and evaluated. Care records contained 'This is Me' documents and social profiles, which included details about the person's life history and things that were important to them, such as particular events or family information. We saw these had been written in consultation with the person who used the service and their family members.

People's care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account. Support plans included mental capacity and DoLS, mobility and falls, nutrition and hydration, medicines, communication, personal hygiene and dressing, skin integrity, elimination and continence, sleep and night care, social wellbeing, and end of life.

Care records showed the service was responsive to people's needs. For example, one person had a wound, which was healing well. The treatment plan was clear, detailed and evidenced the description of the wound, the progress being made, together with observations to be made should the wound deteriorate. A tissue viability nurse was involved in the person's skin care and provided specialist support on what was needed in terms of care and pressure relieving equipment to minimise the risk.

We saw in the care records that end of life support plans were in place for people, which meant information was available to inform staff of people's wishes at this important time and to ensure their final wishes were respected.

Daily communication notes were kept for each person. These contained a summary of support delivered and any changes to people's preferences or needs observed by staff. This helped ensure staff had the latest information on how people wanted and needed to be supported. Handover records showed that people's needs, daily care, treatment and professional interventions were communicated when staff changed duty at the beginning and end of each shift.

We found the provider protected people from social isolation. The home's activities schedule was on display and provided details of activities and events taking place each day. These included dominoes, ball games, baking, knitting, bingo, and singers and entertainers. We observed people going out to the local church, however, the church was closed so people took part in a bingo session with tea and cake.

The provider's complaints policy and procedure was available in an easy to read format and was on display in the home. This described how to make a complaint, how long it would take for a complaint to be acknowledged and resolved, and details of who to contact if the complainant was unhappy with how their complaint had been dealt with.

There had been six complaints recorded in the previous 12 months and two of these were ongoing. Each complaint included details of the investigation carried out and action taken, including records of statements and correspondence with the complainant. Each record included the outcome of the complaint and

whether any further action was required. People and family members told us that when they had raised concerns or made complaints in the past, they had been actioned quickly and effectively.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. They had been registered since May 2012.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

The service had good links with the local community. Local school and nursery school children were regular visitors to the home. The registered manager showed us a card and box of biscuits that had been given to the home by a local school child. The home had good links with the church next door and a ramp had been jointly funded by the home and the church to improve access for people to the church via the home's garden.

The service had a positive culture that was person centred and inclusive. Staff we spoke with felt supported by the management team. A staff member told us, "I love it." Another said, "It's a great place to work." Staff were regularly consulted and kept up to date with information about the home and the provider. Staff meetings took place monthly and staff surveys were carried out every six months.

A family member told us, "I looked at 21 homes, this being the first one. The manager was very approachable and then decided Lindisfarne was the best for the needs of my [relative]." Another family member told us, "I am very happy with this home - they keep me informed." Another told us, "The manager and senior staff are very approachable. I am here every afternoon."

We looked at what the provider did to check the quality of the service, and to seek people's views about it.

The registered manager had an audit matrix in place, which recorded when each audit was due and whether it had been completed. Audits were carried out on a monthly, three monthly or six monthly basis. For example, monthly audits included accidents and incidents, medicines, infection control, health and safety, and safeguarding. Three monthly audits included dining, nutrition, clinical governance, information governance and dementia. Three care records were audited each week and a remedial action plan was in place for any areas of non-compliance from the audits.

The manager carried out a daily walk around of the service, which included the completion of a ten point checklist. This included the cleanliness and tidiness of the home, staff engagement with people and staff attitude, a check of bedrooms, documentation and charts, and general atmosphere in the home. The registered manager conducted regular 'Flash meetings' with senior staff to keep up to date and pass on any important information. The registered manager also conducted out of hours visits at the home.

Senior management visited the home on a regular basis to conduct their own audits of the service and any actions were recorded on the remedial action plan. These visits included a review of medicines, care

documentation, management, health and safety, staffing, the environment, complaints, and staff training.

People who used the service and family members were consulted on the quality of the service via monthly meetings and six monthly surveys. The surveys were analysed to identify any themes or areas of concern, and the results and action taken in response were displayed on the home's notice board.

This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.