

Windmill Hills Care Home Limited

Briardene Care Home

Inspection report

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13 October 2016

26 October 2016

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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?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 11 and 13 October 2016 and the first day was unannounced. This means the provider did not know we were coming. We also contacted an external healthcare professional for feedback about the home on 26 October 2016. We last inspected Briardene in May 2016. At that inspection we were following up on three breaches of regulations which had been found in our previous inspection in September 2015.

Briardene is a care home which provides nursing and residential care for older people, including people living with dementia. There were 49 people living at the home at the time of this inspection.

The service had a registered manager however they had resigned in the week prior to our inspection. The regional manager and a rapid response manager were supporting the deputy manager to run the home following the registered manager's resignation. A registered manager is a person who had registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People living in the home were kept safe from harm. Staff had received safeguarding training and were aware of the different types of abuse people may suffer and their responsibility for reporting any potential signs of abuse.

Systems were in place to identify and minimise possible risks to the health and safety of people using the service.

Robust recruitment systems were in place to ensure staff employed by the service were suitable to work with vulnerable people.

Topical medication records for people using the service were incomplete. We found these did not contain body maps or specific instructions for staff about the application of these medications. We were unable to establish from the records we reviewed whether people using the service had received their topical medication as prescribed. We found records held of oral medication administration were completed. We observed part of a medication round during the inspection and observed good practice throughout.

Feedback received from people and their relatives indicated that staffing levels were not sufficient to meet their needs. Staff members confirmed staffing levels were not always consistently maintained at the appropriate level. Our observations during the inspection were that call bells were not always answered promptly.

Staff were provided with an induction when they first commenced their employment. They were then provided with support through the provision of on-going training relevant to their roles.

Staff had not been provided with the support they required in terms of regular supervisions and appraisals to enable them to perform their roles effectively.

Care plans we viewed were evaluated on a regular basis. However there was limited evidence of people and their family members being involved in care planning. People and their relatives had also not been provided with the opportunity to be involved in regular reviews of their care and treatment to ensure it continued to meet their needs. Despite this people told us they were happy with the care they were receiving and should they have any concerns or problems they would feel confident speaking to a member of staff.

The home had a stable staff team, many of whom had worked at the home for a number of years. This meant people had been able to develop strong relationships with the staff who cared for them. People and their relatives spoke highly of the caring nature of staff.

People and their relatives were provided with the opportunity to be involved in the running of the home through regular resident and relatives meetings.

Complaints records we reviewed were incomplete. Copies of outcome letters were retained but details of internal investigations were missing. It was not possible to tell from the records available whether complaints had been resolved to the complainant's satisfaction. In addition to this, some of the relatives we spoke with told us their complaints had not been responded to.

The service had an activities programme in place to help prevent people from becoming socially isolated. People and relatives we spoke with felt the programme had declined recently. We found the service's activities co-ordinators had been off work for a few months and that a member of staff had just been appointed to undertake this work in their absence.

The provider had a range of systems in place for monitoring and reviewing the effectiveness of the service. However, we found in the months prior to the inspection these had not been used. The homes overall action plan which recorded all areas where improvement was required was also incomplete and had not been updated on a regular basis. This meant it was not possible to determine whether or not action was being taken to improve the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to staffing; complaints; and governance. 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?

The service was not always safe.

Topical medication records for people using the service were incomplete. It was not possible to determine from the records available whether people were receiving their topical medication as prescribed. Other elements of medicine administration were found to be appropriate and effective.

People and relatives we spoke with raised concerns about the staffing levels in the service. We observed call bells were not always responded to promptly. Staff reported staffing levels were not always maintained at the required level. We could not conclude that sufficient staff were always deployed in order to meet people's needs.

Staff had received training in relation to safeguarding people from abuse. Staff were aware of their responsibilities for recognising potential abuse and were able to tell us of the process they would follow for reporting any concerns in order to protect people from harm.

Risks to people, staff and visitors were assessed and appropriate measures put in place to keep people safe from harm.

Requires Improvement ●

Is the service effective?

The service was not fully effective. People had not always given their formal consent to their care and treatment.

Staff had not been provided with the support they required in terms of supervision and appraisal in order to carry out their jobs effectively.

People were encouraged to maintain a nutritious diet.

People were supported to access other healthcare services and external healthcare professional were complimentary about the staff team's response to advice and guidance provided and their proactive approach in raising concerns about the people they cared for.

Requires Improvement ●

Is the service caring?

Good 

The service was caring.

People and relatives spoke highly of the caring nature of staff.

Although people could not always recall seeing their care plan or being involved in regular reviews they told us they were very happy with the care they received.

People's privacy and dignity was respected. People were asked for their preferences in relation to their care and treatment and these were respected.

Is the service responsive?

Requires Improvement 

The service was not always responsive.

People's needs were assessed prior to them joining the service. These needs were then re-evaluated on a regular basis by the staff team. However there was no evidence that people or their representatives had been involved in this process. People had also not been provided with the opportunity to be involved in regular reviews of their care and treatment.

Complaints records were incomplete and did not always confirm whether complaints had been resolved to the complainant's satisfaction.

Regular residents and relatives meetings were held to provide people with the opportunity to be involved in the running of the service. People we spoke with were aware of these meetings and felt these provided them with an opportunity to raise concerns.

Is the service well-led?

Requires Improvement 

The service was not well-led.

Staff told us they had not been provided with the support they needed in order to perform in their roles effectively.

Although systems were in place to monitor and develop the effectiveness of the service, these had not been used consistently in the months prior to the inspection and had not retained an effective oversight of the service.

Documentation held in relation to improvements made to the service was incomplete and out of date.

Briardene 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 between 11 and 26 October 2016 and was unannounced. We visited the service on 11 and 13 October 2016 and spoke with an external professional via phone on 26 October 2016. This inspection was undertaken by one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries, which the provider is legally obliged to send us within required timescales. We also contacted other agencies such as local authorities and Healthwatch to gain their experiences of the service.

During the inspection we toured the building and talked with six people who lived in the home and eight visitors. We also spoke with staff including the deputy manager, rapid response manager, two nurses, two senior carers, two care workers, the activities co-ordinator and three members of ancillary staff. We reviewed a sample of seven people's care records, five staff personnel files and other records relating to the management of the service. We also undertook general observations in communal areas and during mealtimes.

Is the service safe?

Our findings

People told us they felt safe and would speak with a carer or nurse if they had any concerns. A number of people using the service required staff to use a hoist to help them to transfer, for example when getting up on a morning. People told us they felt safe when the staff used the hoist. One person told us; "I'm okay, I'm aware of what's going on," another said "Staff give constant reassurance and I've learnt about the straps" and someone else told us they felt "safe in the hoist." A relative also commented that staff "Seem to know what they are doing with the hoist and [name] has got used to it." People and relatives we spoke with felt the service needed more staff. One relative told us "We worry sick about [name] during the night, they are either understaffed or use agency staff." Another relative told us "We asked for more staff, they said they've got more but we've not seen evidence of it." Although people and their relatives told us they were always provided with a call bell so that they could call for assistance, response times varied and people told us they sometimes had to wait up to 45 minutes for assistance.

We spoke with the deputy manager and the rapid response manager about staffing levels in the home as concerns had been raised about these prior to the inspection. We were informed staffing levels were calculated based on people's dependency levels. In the care records we reviewed we saw people's dependency levels were assessed on a monthly basis and this information was used to determine staffing levels. People and relatives we spoke with told us they felt the home could do with more staff. Concerns were raised about the length of time it took staff to respond to call bells. Comments included; "It can be more than 30 minutes" and "The buzzing goes on for quite a while, they're short staffed." Relatives told us they felt the amount of time people had to wait was unacceptable, with some relatives saying "When staff are asked they say "I'll be there in a minute" and we've had to wait up to 45 minutes." During the inspection we observed call bells were left unanswered for prolonged periods of time.

Staff we spoke with told us staffing levels varied. We were informed where staff members called in sick, their shifts were not always covered. One staff member also told us staff were not always given clear instructions about what they were responsible for whilst at work and that this could have an impact on the speed at which staff responded to call bells. Another staff member told us responding to call bells promptly was particularly challenging at certain times of the day, such as mealtimes. We were informed this was because when people were in the lounge or the dining room there always had to be a member of staff present to supervise them. Staff explained at lunchtime when people were taken from the lounge to the dining room one member of staff had to remain in the dining room and one in the lounge. This meant two staff members were therefore no longer available to respond to call bells during this time. Staff also told us the home cared for a number of people with very high dependency needs and they did not feel the staffing levels accurately reflected this. Staff informed us staffing levels had recently been reviewed and a recommendation made to increase these slightly. Staff felt these new staffing levels if consistently maintained would be sufficient.

We reviewed the rotas for the four weeks prior to the inspection and found these showed staff levels were not always maintained at the level we were informed they should be based on people's dependency levels.

We highlighted the concerns raised in relation to staffing levels with the rapid response manager and the

deputy manager. We were informed staffing levels had been reviewed and a request made to increase these slightly. We saw documentation confirming this. We were however informed as occupancy had decreased slightly staffing levels had not yet increased but that the service would review this again once occupancy increased. The rapid response manager also agreed to consider whether the dependency tool used by the service accurately reflected the level of care and support people required and to review the allocation of staff throughout the home.

Following the inspection we were informed the home was trialling a new dependency tool to help them to determine staffing levels. However, at the time of the inspection it was not possible to conclude that sufficient staff were deployed to meet people's needs. This conclusion was based largely on the feedback we received from people and their relatives about the staffing levels and the time taken to respond to call bells.

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

During the inspection we observed parts of the medication round on both the ground floor and the first floor. The staff members who administered medication checked people's medication on the Medication Administration Records (MARs) prior to giving them to ensure people received the correct medication. Staff members observed good hand hygiene throughout and we observed them explaining to people what their medication was for and seeking their consent prior to administering it. Protocols were in place for the administration of medication on an 'as required' basis and we observed staff members asking people whether they required this medication. We saw dates had been recorded of when medication had been opened and where medication needed to be refrigerated provisions were in place for this.

We looked at the records for one person who received their medication covertly. This is where it has been agreed that a people's medication should be given to them without their knowledge or consent as it is in their best interests for this to happen. The records showed appropriate processes had been followed in order to make this decision in the person's best interests.

We looked at the records in relation to topical creams and ointments for five people. We found these did not contain body maps providing direction to staff on the application of these medications. Written instructions about the application of these medications were also variable. For example one record stated "apply three times per day" but did not provide any advice to staff about where this should be applied. Signatures had only been recorded to show these medications had been administered in one of the records we viewed and these did not demonstrate that the medication had been administered at the frequency at which it was prescribed. This meant it was not possible to conclude from the records available that people using the service were receiving their medication as prescribed.

We highlighted these concerns to the rapid response manager and deputy manager. They agreed body maps and clear directions should be in place for staff to follow in relation to the application of all topical medication. They told us these records would be reviewed and amended following the inspection.

The provider had a safeguarding policy and procedure in place. These documents provided information about the different types of abuse people may suffer and the possible indicators they may display. Information was provided about the process to follow should staff or the provider suspect someone was the subject of abuse. This included contact details for other agencies to whom concerns may also need to be reported. We saw signs were on display in the home in relation to their "zero tolerance" policy on abuse and details were provided of the process for reporting concerns. Staff we spoke with told us they had received training in relation to safeguarding people from abuse and told us they would report any concerns to a

senior member of staff.

We reviewed the service's safeguarding records. These included a log providing a brief overview of all safeguarding incidents as well as individual records for each of the incidents recorded on the log. We saw evidence that incidents were being reported to the local authority safeguarding adults' team as well as to other agencies such as the Police. There was also evidence that incidents were subject to internal investigation.

General risks to people, staff and visitors were assessed. We saw evidence showing that general environmental risks as well as job-specific risks to staff had been assessed. Risk assessments included details of any mitigating factors or actions taken to minimise or manage identified risks. Care records we reviewed showed that potential risks in relation to all areas of people's care and treatment were also assessed. We saw that where completion of a risk assessment in any area of a person's care indicated a risk, a corresponding care plan had been introduced to manage this risk. These risk assessments were subject to regular review.

The provider had systems and contracts in place to monitor the safety of the building and equipment contained within it to ensure this remained safe to use. We saw that regular tests and checks were performed on systems such as the fire alarms and emergency lighting. Equipment such as slings and hoists were also subject to regular tests and servicing. The service had a business continuity plan. This detailed the action to be taken in order to continue the service in the event of an emergency such as the loss of utilities or in the event of severe weather conditions. The service also had an emergency folder which contained individual emergency evacuation plans for each person using the service.

We saw that safe systems were used to recruit new staff. Staff were asked to complete an application form providing details of their previous experience and qualifications as well as their employment history. References were sought to verify the information provided by applicants and staff were asked to account for any gaps in their employment history during their interview. Checks were undertaken with the Disclosure and Barring Service (DBS) to check whether staff had a criminal record and to confirm they were not barred from working in a social care service. Staff's right to work in the UK was verified and they were asked to complete a health questionnaire. Where applicable, checks were also performed on people's professional registration. For example, we saw that regular checks were performed with the Nursing and Midwifery Council to ensure nurses working at the home were registered with them.

Is the service effective?

Our findings

People and relatives we spoke with told us overall they felt the service was effective at meeting their needs. People felt staff were appropriately trained. Comments included; "I'm in very good care here, everything is excellent" and "I think they are all fantastic, most know what they are doing." We were told staff ensured people were able to access other healthcare services where needed. One person told us "They make arrangement for me to see the dentist" and other people told us the GP regularly visited the home. People told us and their relatives confirmed that staff always sought people's consent before providing them with care and treatment. People were also complimentary about their rooms and the home overall with people telling us they were able to bring in personal items in order to personalise their rooms.

The provider's policy for supporting staff included a commitment to providing staff with a minimum of six supervisions and an annual appraisal each year. We reviewed seven staff members' records and found they had not been receiving supervisions and appraisals in line with the provider's policy and procedure. We also found supervisions were being used as a means to correct poor performance but not to provide support to staff. Records we reviewed indicated supervisions had been one sided with staff not being provided with the opportunity to discuss their performance and identify training and support they required. Staff we spoke with told us they had not been receiving regular supervisions and that they had not felt supported in their roles. They informed us supervisions had been used as a means to "tell them off" and that they had often just been asked to sign documentation and no conversation or discussion had taken place.

We highlighted this to the rapid response manager who confirmed they had also received this feedback from staff. The manager was in the process of introducing a new planner to record and schedule supervisions and appraisals for all staff members. Senior staff we spoke with told us they had recently been allocated a list of staff they were responsible for completing supervisions and appraisals for. However at the time of the inspection we found staff had not been provided with the support they required in terms of supervisions and appraisals to perform their roles effectively.

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

We asked to review the service's training records. We were informed following a change in ownership all staff had been asked to complete all of their training again using the new provider's online training system. Staff had only just started to complete their training using this new system and as such their records were incomplete. We therefore reviewed a copy of the previous provider's training records and cross referenced this against the records of seven individual staff members to confirm its accuracy. We found staff training was up to date although we informed the rapid response manager and deputy manager that a number of staff were due for refresher training in relation to safeguarding and moving and positioning. We were informed staff would be reminded of the need to complete training in these areas. Staff we spoke with felt they had been provided with appropriate training to enable them to perform their roles effectively.

We found evidence staff members were provided with a role specific induction when they commenced their employment and staff we spoke with confirmed this. There was also evidence staff were being enrolled to

complete the Care Certificate where appropriate. The Care Certificate is a standardised approach to training for new staff working in health and social care which was introduced in April 2015.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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.

We found a number of people living at the home were subject of DoLS. We reviewed the records the service kept of DoLS applications. We found these were being made to the relevant local authority where deemed appropriate. These were subject to review and action was taken to update or amend these as required.

Care records we reviewed showed people's capacity to make decisions about their care and treatment was assessed by the service. In some records we reviewed where concerns had been raised about a person's capacity to make decisions, referrals had been made to the local authority for a capacity assessment to be completed. Records showed where best interests decisions had been made on a person's behalf these had involved relevant healthcare professionals as well as people's friends or family members.

Formal consent to care and treatment had not been captured in the care records we reviewed. We found care records contained a consent form and care plans had space for the person or their representative to sign to consent to them. However we found these had not been completed in any of the records we reviewed. We highlighted this to the deputy manager and the rapid response manager. We were informed staff were currently in the process of transferring people's care plans on to new documentation. We were informed as part of this process they would ensure formal consent was captured from people or their representatives.

Staff we spoke with were aware of the importance of gaining people's consent before providing them with care or treatment. Staff told us prior to providing care and treatment to people they always explained what they were going to do and sought the person's consent. People we spoke with confirmed staff always sought their consent prior to assisting them. People and relatives we spoke with also told us staff respected people's wishes. One relative told us "They (staff) never force anybody to do anything."

People's care records included a nutrition and hydration assessment. This was used to establish people's dietary needs and preferences. We saw people were also assessed using a recognised Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults are malnourished or at risk or malnutrition. People's nutrition and hydration needs were subject of monthly review and in one of the records we reviewed we saw concerns had been raised following a change in the person's condition. The person's care plan had been updated to reflect the fact staff were now required to "Observe [name] for any swallowing problems" and that should signs and symptoms present, a referral should be made to speech and language therapy.

Prior to the inspection we were informed people had complained about the quality of the food provided.

Most of the people we spoke with during the inspection were not complimentary about the food. Comments included; "It's terrible" breakfast is alright but the rest.....", "When it's good it's very good and when it's bad it's horrid" although another person did tell us they felt the food was "Excellent." They acknowledged "There have been some slip-ups" but then went on to say that on the whole they thought the food was good. We asked the deputy manager and the rapid response manager what action the service had taken in response to this. We were informed following receipt of these concerns action had been taken to obtain information from people using the service about how the menu could be improved. Following receipt of this information the previous manager had introduced an interim menu. Feedback from the residents and relatives meeting held on 5 October 2016 indicated people felt the menu had improved although it was agreed further work was still needed in some areas. We were advised by the rapid response manager that the provider had taken the decision to devise a completely new menu. We were informed this was due to be introduced in the weeks following the inspection and that regular consultation would be maintained with people and their relatives to ensure they were satisfied with the changes.

We observed the lunchtime experience for people using the service. We found the dining areas to be cramped. This meant it was difficult for people and staff to move around freely. Although tables were nicely set, we found table cloths, serviettes and plates were all white, potentially making it difficult for people to see the distinction between their plate and the table. Although people were provided with aprons to protect their clothing, we saw no evidence that aids such as plate guards or special cutlery were available to assist people to eat independently. We highlighted these issues to the rapid response manager and deputy manager. We were informed the service had already identified that the dining rooms were cramped and they were currently exploring the possibility of making changes to these. Following the inspection we were also advised the service had ordered and received specific items of cutlery and adaptations to fit onto plates to support and enable people to eat independently.

Care records contained a record of visits from or contact with external healthcare professionals. People told us they were supported to maintain their healthcare needs. We were informed the GP visited on a regular basis and arrangements were also made for people to visit other healthcare professionals such as dentists. People were complimentary about this element of the service with one person telling us when they had been unwell staff had responded promptly, they told us they were "Taken straight to hospital, the night nurse organised it."

Is the service caring?

Our findings

People and relatives we spoke with were all very positive about the caring nature of the staff. Comments included; "Oh you get well looked after here", "The carers are great here", "[Name] is an excellent carer, she's very thorough in everything she does" and "Some are worth their weight in gold." People felt the staff knew them well; "Most of them have got to know me" and "Staff are very kind. They get to know you." However one of the people we spoke with told us they didn't feel staff always had time to spend with them. They said; "They haven't got time to chat for long. They do what they need to do and then go and help somebody else." People and their relatives confirmed staff members were respectful and caring. One person commented "They are very good; everybody is called by their Christian names." Overall people told us they were very happy with the staff who cared for them and if they needed to know anything about their care and treatment they felt comfortable speaking to staff about this.

During the inspection we observed a relaxed atmosphere in the home. We found people's relatives were free to visit when they wanted and visitors we spoke with told us they were made to feel welcome by the staff. Visitors also commented that they were able to get involved, whether this be with activities taking place in the home, or through attending the regular residents and relatives meetings.

We observed staff were polite, friendly, patient and caring in their approach to people and their relatives. Staff we spoke with were knowledgeable about the people they cared for and showed genuine warmth and affection towards people. During the inspection we observed staff engaging on a one to one basis with people in communal areas of the home. We saw staff got down to people's eye level when communicating with them. We observed people were relaxed and at ease in the presence of staff. We were informed by people we spoke with that the majority of staff had been working at the home for a number of years. Staff members we spoke with confirmed this, as did the external healthcare professional we spoke with. This meant staff had been able to develop strong relationships with people using the service.

Not all of the people we spoke with could recall seeing their care plan or being involved in a review of their care and treatment. We received similar comments from the relatives we spoke with. Some told us they had seen their relatives care plans and could recall being asked about changes. Others could not remember whether they had seen care plans. Despite this, both people and their relatives told us they were very happy with the care they received. They said if they had any concerns or if there was anything they wanted to know they would just ask a member of staff. Relatives felt staff kept them informed about their family members and one commented; "If there's something wrong they'll tell me and if there's anything I want to know they'll tell me."

Staff we spoke with were aware of the importance of maintaining people's privacy and dignity. They were able to give examples of how they would do this, for example through covering people over with a towel and closing the door and curtains when providing personal care. We observed good practice throughout the inspection with staff members knocking on people's doors prior to entering their bedrooms. People and relatives we spoke with confirmed staff respected their privacy and dignity. One person said staff "knock on the door every time they come in" another explained they were "wrapped in a thick, heavy towel" to protect

their dignity when transferring during bathing and another person told us the staff wouldn't let anybody come into their room whilst providing personal care.

People's care records contained information about their preferences and details of how they would like their care and support to be delivered. This included guidance to staff on areas where people required assistance as well as information about what people were able to do independently. For example in one of the records we reviewed it stated; "[Name] will pick her own clothing and prefers to wear dresses." People's care records therefore encouraged staff to assist people in maintaining their independence. People we spoke with confirmed staff were respectful of their wishes and one person told us "The men are quite capable but I get female carers."

During the inspection we observed people were offered choices. For example in relation to what they ate, how they spent their day and whether they wanted to engage in any of the activities available to them. People we spoke with confirmed they were able to make everyday choices.

In the care records we reviewed we saw evidence people had been asked about their wishes in relation to their care and treatment at the end of their lives. This included their wishes in relation to resuscitation.

Is the service responsive?

Our findings

People told us the service was responsive to their needs. One person told us when they asked to move rooms this had not been a problem. Another person told us their care plan had been adapted to meet their needs and another person said; "If you want something they'll (the staff) get it for you." We received similar comments from a relative who told us they had met with staff in order to discuss their relative's care plan when they first moved into the home. People told us they were offered a variety of activities and that this included the opportunity for them to be involved in activities or outings outside of the home; "We go to the Irish club in town," "Sometimes they take you to Newburn park for a meal," "We've been to St Mary's Island and Hadrian's wall" and "One of the trips I really enjoyed was to the bowling alley."

People and their relatives told us they knew what to do if they had a complaint; "I'd complain to the boss" and "I tell them what I think, I would complain to the nurse." People and their relatives also told us they were provided with the opportunity to attend regular meetings and to be involved in the running of the service.

We reviewed the provider's complaints file. We found eight complaints were recorded as having been received in the previous 12 months. The file contained a complaints log as well as individual records in relation to each complaint. However we found the records held were variable. The complaints log was not fully completed and limited documentation was held in relation to each complaint. For example we saw copies of outcome letters sent to complainants were retained in the file but there was no indication of any internal investigation having been conducted. It was not always clear whether or not complaints had been resolved from the documentation that was available.

People and relatives we spoke with told us they knew what to do if they had a concern or a complaint. Most of the people we spoke with told us they did not have any complaints; "I've got nothing to complain about" and "We've got nothing to complain about." The majority of people we spoke with told us they felt complaints would be taken seriously and responded to appropriately; "I know they would listen." However, two of the relatives we spoke with told us they had complained about the length of time their relatives had to wait for assistance to go to the toilet and that this had not been responded to. They also told us the service did not always respond to their requests. For example they told us their relative liked a milky drink on an evening and that despite asking for this to be provided this was not done consistently.

This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

In the care records we reviewed we saw a pre-admission assessment had been completed in order to determine whether or not the service was able to safely meet a person's needs. The pre-admission assessment included details of the person's needs in areas such as communication, mobility, medication and personal care. It also provided details of the person's medication history and information about their mental health and capacity.

Following a person's admission to the service we saw a full assessment of their needs was then completed. This was broken down into each area where a person may require assistance, including; personal care and

physical well-being, medication usage, mobility and dexterity, sleep and rest, nutrition and hydration, mental state and cognition, continence and social interests, hobbies, religious and cultural needs. As part of this process potential risks were identified for example in relation to malnutrition, skin integrity and falls. Care plans were then created for each area where a person required support or assistance. Care plans provided guidance to staff on people's preferences in relation to their care and treatment, for example in relation to the gender of care staff providing personal care. Care plans were subject to monthly evaluation by staff and we observed where there was a change in a person's needs their care plan was updated to reflect this.

We were informed people should have been involved in six monthly reviews of their care and treatment, however we saw limited evidence that these reviews had been taking place. Despite this, people and relatives we spoke with told us they were happy with the care they received and if they had any concerns they would raise these with a member of staff. People also felt the service was responsive to their needs and one relative explained how when their family member had moved into the home they had met with staff and their relative's social worker to adapt their care plan accordingly.

We discussed the fact we could not find evidence six monthly reviews had been taking place with people and their representatives with the deputy manager and the rapid response manager. They confirmed these had not been taking place as frequently as they should have been and this had already been identified as an area for improvement. Following the inspection we were informed the service had scheduled care plan and assessment reviews with each person using the service.

We saw monthly residents and relatives meeting were held to provide people with an opportunity to be involved in the running of the home and to provide feedback. People and relatives we spoke with were aware these meetings took place and a number of them attended these. People told us they felt these meetings had an impact with one person saying; "I've seen improvements as a result" although some of the relatives we spoke with felt this was not always the case.

We found the service had a weekly activities programme, details of which were on display throughout the home. People we spoke with told us activities took place on a regular basis and they were complimentary about the activities on offer to them. People told us they were encouraged to use the outside space at the home and were also provided with the opportunity to attend trips. However people and relatives told us they felt there had been a decline in the activities programme in the previous months. Comments included; "I think we could do with a little more" and "Been a bit in limbo", with another person telling us they hoped things would "Get back to normal." People told us they felt this had been caused by changes to the staffing arrangements.

We spoke to the deputy manager and rapid response manager about this. We were informed the two activities co-ordinators had been off work for a while but that another member of staff had recently offered to undertake this role as an interim solution. We spoke to this staff member who confirmed they had just been told they would be undertaking this role on a full-time basis. Prior to this they informed us they had been doing a combination of activities and care and this had been quite challenging. They said this meant they hadn't always been able to fully deliver the activities programme. This confirmed what people had told us.

During the inspection we also noted there were limited activities available for those people who were nursed in bed. We highlighted this to the rapid response manager and deputy manager. They told us they would discuss this with the new activity co-ordinator and ensure one to one activities were also included for people using the service.

Is the service well-led?

Our findings

People and relatives we spoke with told us the service had been a little unsettled recently. One relative commented that there had been a number of management changes over a relatively short period of time. Other people we spoke with told us the service had declined recently. Comments included; "It has been lovely and then it has gone down a bit", "In the last few months we've seen a change" and "It was an absolutely fabulous place, now everybody's down." However, overall people and their relatives were positive about the service as a whole telling us; "I like it here, I've got plenty of friends" and describing the home as "fabulous, I haven't got anything bad to say about the place."

We found the service had a range of systems in place for monitoring the quality of the service. These included a variety of audits and checklists in areas such as health and safety, medication, care plans and infection control. Monthly audits in key areas such as medication, nutrition and health and safety had not been taking place. In addition to this, we found some of the documentation used to complete audits did not provide space to capture areas for improvement or action taken as a result of completion of the audit. We also found the home's overall action plan, which we were advised should contain details of all areas where improvement was required was incomplete and had not been updated on a regular basis. This meant it was not possible to determine whether or not action was consistently being taken to improve the service.

During the inspection we found documentation was not always fully completed. For example we found some medicines records had not been fully completed, care files were not always reviewed as regularly as the providers policy stated, people had not been asked to formally consent to their care and treatment and complaints records were not completed in a good level of detail. The systems in place to audit these areas had not highlighted these issues prior to our inspection, or resulted in actions being taken to address the issues we found during the inspection.

When we highlighted these issues to the deputy manager and rapid response manager they accepted record keeping had not been maintained at the level the provider expected and that this had already been identified as a general area of improvement. During the inspection we saw action was taken to start addressing some of these areas. The rapid response manager spent time going through documentation held in the office, re-organising it and identifying where further records were required. However at the time of the inspection we could not conclude that accurate, complete and contemporaneous records were held.

We found the provider had not been conducting regular inspections or reviews of the service, to ensure it was meeting the necessary regulations. Records indicated the last compliance visit had been conducted in June 2016. Following this the only other checks that had been performed were those undertaken by the current rapid response manager when they had become involved with the home in September 2016. In addition to this the service had been holding regular meetings with people, their relatives and staff in order to get their views about the service. Questionnaires were also available in order to obtain feedback from people and external healthcare professionals. However, we found these systems had not been fully utilised for a number of months.

These issues were a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Records we reviewed showed regular meetings had been held with the staff team. These included senior staff meetings, flash meetings and all staff meetings. We found minutes were kept of meetings. These showed topics discussed included training, policies and procedures, concerns with specific people using the service as well as feedback. Staff we spoke with confirmed they had the opportunity to attend regular staff meetings. Although staff told us these meetings provided them with the opportunity to raise concerns, they did not always feel as though action was taken as a result.

The service had a registered manager; however we were informed they had resigned the week prior to the inspection. At the time of the inspection, a rapid response manager and an area manager had been brought in by the provider to assist the deputy manager in overseeing the day to day running of the home until a new manager was appointed.

The majority of staff we spoke with told us they had not felt supported in their roles by the registered manager. Staff told us the registered manager had not always been approachable and that they had tended to spend their time in the office. We were informed by staff that morale in the service over the months prior to the inspection had been poor. Staff told us they felt the registered manager had not always taken action in response to concerns or issues raised with them and they had not been a visible presence within the home.

We spoke with the rapid response manager about these comments and the concerns that had been raised about the registered manager and the service as a whole prior to the inspection. We were informed concerns had been raised with the provider about the registered manager's ability to manage the home. These concerns were raised by Healthwatch after they attended a residents and relatives meeting in September 2016. Concerns related specifically to a lack of management and direction in the home as well as people's dissatisfaction with the food available to them. As a result, we were informed additional support had been put in place to assist the registered manager. This included members of senior management attending the home on a regular basis to support the manager in addressing the concerns that had been raised. We saw evidence work had been undertaken in terms of reviewing and improving the menu and that early feedback from people using the service had been positive. The rapid response manager advised that following the registered manager's resignation they would be looking at completing a full audit of the service and updating the home's overall action plan to reflect details of all actions required. We received positive feedback from the staff we spoke with about the support being provided by the rapid response manager and the area manager. Staff told us they had been kept informed about what was happening in the service and felt their concerns and comments were now being taken on board.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Diagnostic and screening procedures	The registered person had not ensured that an accessible system for identifying, receiving, recording, handling and responding to complaints was in operation.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	The registered person had not assessed, monitored and improved the quality and safety of the service provided in the carrying on of the regulated activity.
Treatment of disease, disorder or injury	
	The registered person had not ensured that accurate, complete and contemporaneous records were maintained in relation to each service user, including a record of care and treatment provided.
	17(2)(a)(c)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Diagnostic and screening procedures	The registered person had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed.
Treatment of disease, disorder or injury	
	The registered person had not ensured persons employed by the service received appropriate support, training, professional development,

supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

18(1)(2)(a)