Careline Lifestyles (UK) Ltd

Deneside Court

Inspection report

St Josephs Way
Jarrow
Tyne and Wear
NE32 4PJ

Tel: 01915191574
Website: www.carelinelifestyles.co.uk

Date of inspection visit:
17 January 2017
02 February 2017

Date of publication:
29 December 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 17 January and 2 February 2017.

Deneside Court is a 40 bed purpose built home and provides residential and nursing care to adults with learning disabilities and physical and neurological disabilities. At the time of the inspection there were 28 people using the service. The home was divided into three units. The ground floor unit comprises of 20 individual apartments with en-suite facilities. While the two upper units comprise of 20 self-contained flats which each contained kitchen facilities.

We had previously carried out a comprehensive inspection of Deneside Court on 28 July followed by 29 July, 4 and 11 August 2016 following concerns raised by external health and social care professionals and the police. At the inspection we found there were breaches of six of the Fundamental Standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified multiple concerns in respect of the safe care and treatment of people using the service. The registered provider failed to provide safe management of medicines. Staffing levels were insufficient to meet the assessed needs of people using the service. The registered provider's recruitment process did not cover the reviewing or checking of agency staff's clinical competencies or training. People's health and nutritional needs were not being met in a safe manner. The registered provider did not ensure staff received appropriate training and development to enable them to carry out the duties they were employed to perform.

The registered provider was not following the principles of the Mental Capacity Act 2005, no records of best interest discussions were available. Staff were not aware of people who were subject to a Deprivation of Liberty safeguard. Care records did not reflect people's needs and preferences. The registered provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and failed to ensure that people received appropriate care and support.

We undertook this comprehensive inspection to check that the registered provider now met legal requirements. During this inspection we found the registered provider had implemented actions and some improvements had been made. However, we found the registered provider continued to breach four of the Fundamental Standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An inspection of the registered provider's management of medicines procedures was undertaken by two pharmacy inspectors. Medicines were not managed safely. People's records were not clear to demonstrate that medicines were administered. The stock balance of medicines was not accurate. Care plans relating to medicine administration had not been reviewed. Where people were prescribed as and when medicines, protocols for their administrating were not up to date. Prescribed medicines were not being administered in line with the GP prescription. The ordering system used for ordering medicines was not effective. Medicines were being used that were past their use by date. Keys for the excess stock cupboards and refrigerators were

left unattended in the locks. Temperature recording of the refrigerator used to store medicines was not being consistently recorded.

People's emergency evacuation plans (PEEPS) were not up to date, putting people at risk in the event of an emergency. Actions from recent fire audits seen at the last inspection had not been completed.

We found the registered provider was not always acting in accordance with the Mental Capacity Act in relation to people's Lasting Power of Attorney. The registered provider was not always aware of people's arrangements for decision making and seeking consent.

Staff had not received regular supervision and appraisal. The registered provider had not checked the competencies of all new agency staff who formed part of the regular staffing team.

We found staff levels were appropriate to meet people's needs. Staff reported the service had improved in relation to staffing levels with dedicated staff deployed on each unit. Staff felt the service was now a safe place to work.

People accessed the community and took part in a variety of activities. Two activity coordinators provided support to people to continue with hobbies and interests. People were encouraged to prepare their own meals as part of their support. A choice of meals were available for people.

The service employed a therapeutic services team who worked closely with people to support positive behaviour strategies. People had access to the hydrotherapy pool as part of recreational and therapeutic activities.

We found evidence in care records to demonstrate referrals were made to community services when necessary. We found records of visits to and from health care professionals including dieticians, dentists, GP's and community nurses. Social care professionals told us the service was providing a supportive environment and people they had commissioned support for had experienced positive outcomes.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service had a peripatetic manager (manager) who was overseeing the management of the home. The manager confirmed that they intended to submit an application to become the registered manager of Deneside Court. The manager was being supported by the Director of Nursing and Quality. Both acknowledged that areas of the service need improvements to be made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Medicines were not managed safely. People's records were not clear to demonstrate that medicines were administered. The stock balance of medicines was not accurate.

Fire safety assessments had not been addressed following input from the local fire authority. Fire doors were found to be wedged open. People's personal emergency evacuation plans (PEEP) had not been reviewed and updated for more than two years.

The service ensured that prospective employees were suitable for the role and carried out safe recruitment practices before offering employment.

People had individual personalised risk assessments in place which were reviewed. Assessments contained interventions to minimise risk.

Health and safety certificates were in place to demonstrate that checks had been carried out. For example, gas safety and portable appliance testing.

Is the service effective?

Requires Improvement

The service was not always effective.

We found some agency staff were not receiving the same checks as employed staff to ensure they had the skills and competencies to deliver safe care. Supervision and appraisals were not being completed with staff as per the provider's own policies and procedures.

The provider did not always act in accordance with the Mental Capacity Act 2005. The registered provider did not always know about people's appointed Lasting Power of Attorney.

Fire safety assessments had not been addressed following input from the local fire authority. Fire doors were found to be wedged open.

The registered provider had employed a clinical lead to support nurses with revalidation and to provide clinical supervision and competency checks for nurses. Supervision had commenced with employed nurses.

Health and social care professionals were involved in people's care. For example, speech and language therapists and GPs.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and promoted independence were possible.

Staff knew people well and were able to describe the individualised support they needed. People felt staff were caring.

Positive relationships were evidence between staff and people.

There was information about advocacy arrangements and facilities offered by the service, readily available to people who use the service, relatives and any visitors.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care records and risk assessments were more personalised. Details regarding people's specific outcomes were recorded, as part of a pilot using the Outcome Star tool.

The service made referrals and liaised with community services when necessary including dieticians, community psychiatric nurses and advocates.

The service had a complaints policy in place and people told us they knew how to make a complaint. No formal complaints had been raised since the last inspection.

Is the service well-led?

Inadequate

The service was not always well led.

The provider was not able to demonstrate that they had developed and implemented effective governance arrangements including quality audits.

People and staff found the manager was approachable and

supportive.

People, relatives and staff had opportunities to engage about the direction of the service and make suggestions for required improvements.

Deneside Court

Detailed findings

Background to this inspection

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

The inspection took place on 17 January and 2 February 2017.

The inspection was conducted by two adult social care inspectors, one inspection manager, two pharmacy inspectors, an expert by experience and a specialist advisor who is a Primary Health Facilitation Nurse Specialist with the NHS (National Health Service). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. This inspection was also carried out jointly with an officer from the local fire authority.

Before the inspection, we reviewed the information we held about the service, including the notifications we had received from the registered provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also gathered information from South Tyneside Healthwatch, South Tyneside Council Safeguarding, South Tyneside Clinical Commissioning Group, and South Tyneside Council Commissioners. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we observed staff interacting with people and looked around the premises. We spoke to the manager, Director of Operations, Director of Nursing and Quality, deputy Director of Nursing, the administrator, three nurses, ten staff members, two team leaders, and the therapeutic services team. We also spoke with two visiting health and social care professionals.

We spoke with nine people who used the service and six relatives for their views on the service.

We viewed a range of records about people's care including medicine administration records, training records, dependency tools, quality audits and statutory notifications.

Inadequate

Is the service safe?

Our findings

When we last inspected the home we found the home was not safe and the registered provider had breached regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The registered provider had failed to provide safe management of medicines. Staffing levels were not at an appropriate level to provide safe care. People's risk assessments were generic and not reviewed in line with people's changing needs.

At this inspection we found that the provider had continued to breach regulations. We looked at the systems in place for medicines management. We reviewed nine medication administration records (MARs) and looked at the storage, handling and stock requirements.

We observed that medicine trolley keys were held by the nurse on duty, however the keys for the excess stock cupboards and refrigerators were left in the locks. This meant access to medicines was not restricted to authorised staff. The home's policy stated fridge temperatures were to be recorded twice daily; however we found that on 10 occasions, on the second floor and three occasions on the Keller unit, in January 2017 temperatures had only been recorded once daily and for all occasions only current temperatures were recorded not maximum or minimum. Recorded room temperatures were within the recommended range for storing medicines however, temperatures had not been recorded on the second floor on two days in January 2017.

The nurse showed us the arrangements for disposal of unwanted medicines. Although a contract was in place with the Pharmacy for the disposal of medicines, we found the container used did not meet waste regulations. This was unsafe practice and had been highlighted at the last inspection.

The majority of MAR charts were printed by the community pharmacy. Where handwritten entries were made, two nurses did not always sign them, which was not a safe practice in line with national guidance and was highlighted as part of the last inspection.

We checked the processes in place for stock balance and ordering of medicines. The ordering system used at the home was not effective; we saw external items were over stocked and that one eye drop for one person had expired. Expiry dates were recorded on opened medicines in most cases however we found one liquid which was still in use past its 30 day expiry period and two bottles of eye drops with no date of opening recorded. This meant that staff could not be sure these medicines were safe to administer. These areas had also been identified during the previous inspection. Carried forward balances, which are used at the start of the medicines cycle to ensure accurate stock balances of medicines, were not maintained because medicines were not carried over from one month to another.

Administration signatures on the MAR charts did not match with the quantities of boxed medications. The home had a boxed/bottled medication balance sheet, which they used alongside the MAR to ensure accurate stock recording; however, this was not used correctly and did not record all administrations. When as required medicines were given these were not always recorded on the back of the MAR as detailed in the

medication policy. This meant staff were unaware why medicines had been administered or if they had been effective; this was unsafe practice. We identified this as part of the previous inspection and we found this had continued as part of this inspection. When as required medicines were administered the times were not always recorded. For those when times had been recorded this had not been reviewed and administration had occurred sooner than the prescribed interval. This meant there was a risk people may receive more medicines than they should, which could put their safety at risk. Medicines which were prescribed with a variable dose did not always have the dose given recorded, so staff could not be sure of the total quantity administered in a 24 hour period. When medicines were not administered the appropriate code was not always recorded to demonstrate why the medicine had not been given.

During this visit we were told by the nurse on duty that one person's medicines were "potted up" as part of the morning medicines round and the MAR was signed as administered. These medicines were then stored in the trolley until the resident woke later in the day. This is not in line with the homes policy or national guidance and was an unsafe practice.

Medicines continued to not always be administered as prescribed. For one person Lansoprazole had been prescribed to be taken once daily alongside Ibuprofen. However we saw that on four occasions in January ibuprofen had been administered but the Lansoprazole had not been given. This increases the risk of harm to the person from a stomach upset or bleed. For a second person a medicine which had been prescribed by a consultant had not been transcribed to the MAR correctly. In addition, this had been missed off the next MAR and had not been administered since November 2016. Failure to administer medicines as prescribed increases the risk of harm to health and wellbeing. A third person who was prescribed Zopiclone had received one dose in the early hours of the morning and a second dose the same evening. It had been noted in the support plan that the person had seemed heavily sedated. Taking two doses of a hypnotic within 24 hours increases the risk of over sedation, falls and decline in mental function. We raised these concerns with the provider during the inspection and referred these concerns to the local safeguarding authority for investigation.

One person was prescribed Lorazepam. Lorazepam is used for the management of anxiety disorder, the short-term relief of symptoms of anxiety or anxiety associated with depression. There was no up to date as required protocol in place for the management of administration of this medicine. The protocol in place contained incorrect dosage of Lorazepam. Staff told us the person comes and requests the medicine and was given a dosage of 2mg. We found that a higher dose had been given. When we asked staff why this dosage had been administered, a senior staff member informed us, "A lower dose does not touch her." There was no care plan in place to rationalise dosage of the medicine according to the person's behaviours rather than when they request the medicine themselves.

We reviewed four care plans which were specific to medicines. We found they were not up to date or reviewed at the appropriate frequency. We found that as required protocols had not been reviewed and updated when changes had occurred. This increased the risk of people not receiving care which met their individual needs.

We were shown two audits from 10 January 2017, which had been completed by staff. Staff deemed 'the apartments' as 85% compliant and Morris unit 80% compliant. Two actions had been identified however the audit had failed to detect the shortfalls we identified. We were also shown an independent review which had taken place on the 12 January 2017, which had identified the same areas of concern as we found in our inspection and a 44 point action plan had been developed but the Director of Nursing and Quality confirmed that at the time of the inspection no progress had been made against those plans.

The provider had an up to date fire safety procedure but the guidance for staff on how to report a fire to the Fire Service was incorrect as the address of the service was incorrect. The provider's procedure contained the wrong street name and wrong postcode. This meant guidance for staff on what to do in the event of a fire was inaccurate and increased the risks associated to service users and staff in the event of a fire.

Each person had a personal emergency evacuation plan (PEEP) which contained details about their individual needs should they need to be evacuated from the building in an emergency. 14 PEEPs had not been reviewed and updated for more than two years. This meant we could not be sure the information in people's evacuation plans was up to date and reflected their current needs.

These findings demonstrate a continuing breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We were accompanied on the inspection by a fire officer. A review of the registered provider's fire risk assessment had been requested by the Fire Service in October 2016. This had not been addressed. The fire officer requested a thorough review of the registered provider's fire risk assessment to be conducted as a matter of urgency. Along with remedial works highlighted by the fire officer in relation to fire resisting doors to ensure they conform to British Standards and to make staff aware of the unsafe practice of wedging open fire resistant doors which had been observed during the inspection.

At the last inspection the fire audit completed in June 2016 contained 13 actions with only two being completed. During the inspection we found the fire audit agreed action plan remained in place with no managerial sign off to evidence that the agreed actions had been addressed. We viewed the service's fire risk assessment which had not been updated since October 2015. The provider's fire risk assessment stated one person had oxygen in their room but we noticed during our inspection that two people who used the service had oxygen. This meant the risk assessment was not safe in respect of oxygen management. During the second day of the inspection we saw evidence that an external contractor had been commissioned to complete a fire risk assessment of the full building. This took place on 24 January 2017, at the time of our inspection the provider was waiting for the full report to be issued. Information relating to fire safety procedures was clearly displayed in communal areas for people and visitors and was in pictorial format so it was accessible.

At the previous inspections in July and August 2016 we found there were not always personalised assessments and information about people's significant areas of risk. During this inspection we found improvements. The risk assessments we examined covered areas of individual risk. For example, choking, falls and behaviours that challenge. The risk assessments included control measures to reduce the risks. This meant staff now had clear information about risks and the action they needed to take to minimise them.

We checked the recruitment files of two new employees that had joined the service since our last inspection in July 2016. We found that all Schedule 3 requirements were in place relating to safe recruitment. This included application forms, interview documents, identity checks, references, professional registration checks and checks of qualifications held. Both new employees had also received clearance from the Disclosure and Barring Service (DBS) that they were able to work with vulnerable adults and that they could do so without restriction.

The service had a range of policies and procedures to keep people safe, such as safeguarding and whistleblowing procedures. These were accessible to staff for information and guidance. The training matrix showed safeguarding training was out of date for 15 staff out of a total of 66. The registered provider had

booked six staff members on to the next cohort of safeguarding training with the remaining staff being allocated spaces on subsequent sessions.

Staff we spoke with understood their safeguarding responsibilities and told us they would have no hesitation in reporting any concerns about the safety or care of people who lived there. Staff said they felt confident the manager would deal with safeguarding concerns appropriately.

Safeguarding referrals had been made and investigated appropriately. A log of all concerns was kept up to date and staff had access to relevant procedures and guidance. Appropriate action had been taken following safeguarding incidents, for example one person's care plan had been updated to reflect control measures to reduce a specific risk. Information about how to report safeguarding concerns was on display around the building for people and visitors.

The manager told us and records confirmed that safeguarding and whistleblowing were regularly discussed at staff meetings. The manager said, "I'm not frightened to raise safeguarding alerts. I discuss safeguarding with all staff as it's everybody's responsibility." This meant the service had a positive approach to safeguarding.

One staff member told us, "I felt at risk whilst at work before. I raised it but there was no real improvement. It's getting there now. Staffing levels and consistency of staff has improved." A relative commented, "It's safer than what it was."

The registered provider used a dependency tool to determine staffing levels and were using individual dependency assessments which had not been regularly reviewed. The Director of Nursing and Quality told us, "We are reviewing the dependency tool as the current one does not reflect differing needs." We were given an example of the dependency tool the service was planning to utilise. During the second inspection day we found the manager had completed the new dependency tool as a pilot for one of the units which determined the current staffing levels to be appropriate. The manager told us, "Training in the use of the new dependency tool is being carried out during February; we are looking at using the tool in each unit looking at the most dominant need. I hope to have everyone assessed and each unit using the tool by the end of February."

We reviewed the current week's rota and recent weekly rotas. We found a significant number of agency staff were still being used by the service. The manager told us, "We are trying to have continuity of staff when using agency. This is happening now with the same staff covering the shifts. We now have a number of nurses that are consistently working at Deneside Court." We saw there was some consistency with the same the agency staff being used. We spoke with one relative who felt agency staff were not familiar with their family member's needs. They explained key aspects of their relatives care and accommodation, which were in place to support their assessed needs, were not always updated. One person considered staffing levels to be inadequate and told us it was normal for buzzers to go unanswered. They explained, when staffing levels were not sufficient for people to be supported in spending time in the community, this could trigger disruptive behaviours which made them feel unsafe. Another person told us, "I get out and about there are enough of them (staff) on the unit." A third said, "It's better now, we have more time with them (staff)."

At the previous inspection staff told us they were frightened by the behaviours of some people who used the service. Staff we spoke with told us they now felt safe and staffing levels had improved. One staff member told us, "Staffing levels have improved on days and nights." Another told us, "It is so much better, having separate staff working on the units." During the inspection we saw an improved staff presence on each unit. One staff member told us, "I did not feel safe last year but I feel safe now". Another told us "Sometimes

behavioural management is not always consistent which affects [person's] behaviour." We asked people if they felt the service was safe. One person told us, "I feel safe; [name of nurse] is my favourite nurse." Another person told us, "I am very safe in here I have my own place."

One person required one to one support for a number of factors, of which one was behaviours that challenge. The risk to staff had been assessed and the service were using walkie talkies to allow communication between the staff and the team leader in case of emergencies. We spoke to staff who worked with the person. One staff member told us, "The walkie talkies don't always work, but I don't feel that [person's] behaviour would prevent me from gaining support" From conversations with the support worker it was clear they knew the person well and were able to describe the persons behaviours that showed they were becoming agitated. The staff member told us, "I then withdraw and give [person] some time and space, I have worked with [person] since they came here, I know their ways." We discussed the issue of the walkie talkies with the manager who advised staff sometimes don't use them correctly and use the wrong button. They told us, "There are laminated posters around the unit of how to use the handsets." We found posters were in place and saw the walkie talkies in use.

The provider had reviewed the deployment of staff in the service. Each unit in the home was now staffed with a dedicated team, with one nurse working downstairs and one working upstairs. Each unit had a team leader who was supernumerary which allowed time for care planning reviews and management of care workers, along with supervision sessions. We spoke to staff about these changes. One team leader we spoke with told us, "Prior to the last inspection it was unusual to sit down to work without being interrupted." We found this to be a positive impact whereby staff had more time to carry out their duties.

At the last inspection we found staff were not able to describe specific care delivery for people with complex needs. At the last inspection there were several people with complex nursing needs, some of these people have moved out of the home in recent months. We reviewed the care provided to one person who had complex needs by way of a percutaneous endoscopic gastrostomy (PEG) and a tracheostomy. A PEG is a tube which is passed into a person's stomach to provide a means of providing nutrition when oral intake is not adequate. A tracheostomy is an incision in the windpipe which allows a person to breath without the use their mouth and nose.

Staff we spoke with were well versed in PEG feeding and tracheostomy care and were able to answer questions regarding people's care. For example, the need for the person to be in a 45 degree angle whilst the feed was being administered, the feed and flush regime needed as well as the emergency plan if the PEG became dislodged. We found there were two members of staff on duty at all times who were trained in the person's complex needs. The person required half hourly oxygen levels to be recorded as well as positional changes, oral hygiene and the application of leg splints. We did find some gaps in the recording of oral hygiene over three to four days, this was discussed with the nurse on duty. Other records were recorded consistently.

Staff we spoke with were able to describe the use of arm and leg splints and how these were applied. One staff member told us, "We apply [person's] splints as part of their daily routine, they have them on for an hour only." These comments were consistent with the person's support plan.

The registered provider had health and safety certificates in place to demonstrate that checks had been completed. For example, gas safety and portable appliance testing. Equipment used for the moving and assisting of people had been checked with reports of hoist slings being checked for wear and tear.

A grab bag had been put together in the reception to use in an emergency situation. The bag contained

emergency contact numbers and torches. A large torch had been purchased for each unit in case of electrical failure.

Requires Improvement

Is the service effective?

Our findings

When we last inspected the home we found the home was not effective and the registered provider had breached regulations 11, 12, 13 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The registered provider was not following the principles of the Mental Capacity Act 205. No consideration had been given to whether people were being deprived of their liberty. Staff had not received appropriate training to ensure people received safe and effective care. This included training in managing medicines and appropriate training in relation to specific clinical care needs people had, such as PEG care and tracheostomy care. We found support workers had not received regular supervision and an annual appraisal. Nurses had not received clinical supervision or reviews of their competency.

The registered provider had submitted regular updates to CQC regarding the competencies of staff who were responsible for administration of medicines as part of their condition of registration. Although competencies had been completed for permanent staff and agency staff used at the time of their submission of evidence, we found the effectiveness of the safe handling of medicines competencies were not robust as the service continued to breach regulations in relation to safe care and treatment by not managing medicines safely.

We found some agency staff had no evidence of clinical competencies being checked or carried out by the registered provider. We raised this with the manager and requested evidence of staff competencies for these staff. We were provided with a file containing agency staff profiles. Profiles stated that staff had skills in PEG, tracheostomy care, use of suction apparatus. One agency nurse had signed an agency competency agreement, this was a tick box document. The document did not contain when competencies were checked, by whom and where.

Following the last inspection we were advised that the HR manager would check the competencies of agency staff. On the second day of the inspection the administrator told us they would contact HR and transfer the call to us so we could speak to them. We did not receive a call to speak to HR. We discussed with the manager that the registered provider had to demonstrate they met the requirement of the regulations about staff being competent to deliver safe care and to be able to evidence this. The manager advised that they would check that agency staff were appropriate to work in the service and felt that as nurses, agency staff were responsible and accountable when they confirm they were competent. This meant no records were completed for newer agency staff to determine competency checks had been completed. As agency staff become a member of the service's staff they should be subject to the same checks as directly employed staff.
The manager provided an up to date training matrix. This confirmed that staff training was being addressed. We were provided with a list of up and coming training covering subjects such as fire, food hygiene, moving and handling and infection control for January and February 2017. The manager told us, "Further training sessions to cover the rest of the staff will be booked in once these have been completed."

The registered provider's action plan stated that diabetes care training had been booked with dates and places confirmed. We found no staff had completed up to date diabetes training at the time of the

inspection. The manager advised they had been in contact with an external contractor for distance learning training for staff. The agency were due to attend the service in March 2017 to sign up staff for several different subjects which will include diabetes and nutrition. The manager had also requested training on the principles of team leading for the team leaders to enhance their skills to meet their roles in providing support for staff. We found the nurses working on a unit where people may present with behaviours that may challenge were not trained in MAPA. We discussed this with the manager who told us, "They are registered mental nurses with experience in challenging behaviour." The manager advised the nurses would be booked on the next MAPA training course.

We spoke to staff about their training. One staff member told us, "The training I completed when I started was alright for downstairs but you need more training upstairs." Another told us, "We have had the right training." A third told us, "The MAPA training was good." The registered provider submitted a matrix of positive behaviour training which staff had just completed to support with managing people who demonstrated behaviours that may challenge. Further training in this subject was booked in for the remaining staff during January and February 2017.

We reviewed staff competency records for PEG care, tracheostomy care, MAPA (this is a special type of training used to assist people who have behaviour that challenges) and safe handling of medicines. We found records were in place to demonstrate training and competency checks for permanent members of staff but not all agency staff.

The above demonstrates a continuing breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure 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 saw 16 DoLS applications had been authorised by the relevant local authority and six DoLS applications were awaiting approval. DoLS applications contained details of people's individual needs and how decisions made about DoLS were in people's best interests, such as the use of a lap strap when someone was in a wheelchair or the use of bedrails when someone was in bed.

Records relating to DoLS authorisations and advocacy were inconsistent. It was not always clear when another authorisation needed to be applied for and details relating to advocacy weren't always accurate. For example, in one person's care plan it was noted they have an advocate but this information was not on the advocacy list provided by the manager. This meant there was not a clear and effective system in place to monitor DoLS or people's advocacy arrangements.

The registered provider was not recognising people's Lasting Power of Attorney (LPA) correctly. A LPA is a legal document in which one person nominates and gives legal authority to another to act on affairs on their

behalf. We found where consent was needed or decisions made regarding a person's well-being, staff were contacting next of kin and not checking to see if the person had a LPA in place. People's consent to care was not always clear in their care plans. One person's care plan was signed by a staff member but not the person or their representative.

We discussed this with the manager who following the inspection developed a log of people who they knew had nominated a LPA, as well as contacting families to ascertain if individuals had a nominated a LPA.

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

We requested and were provided with the supervision and appraisal plan for 2016 – 2017 along with copies of the supervision and appraisal policy. The policy stated staff were to receive supervision at a minimum of six times a year. The spread sheet recorded supervisions and appraisals from January to December 2016 this showed that staff had not received supervision and appraisal in line with the registered provider's own policy and procedure. We found 14 supervisions completed in January 2017. No other dates were planned for 2017. We spoke with staff about whether they received supervisions One staff member told us, "Yes, six sessions a year to discuss how your feeling, how your key working is going which is really helpful." Another said, "They [supervisions] are much better now, regular which is good, we can go at any time to speak with [manager]." The manager told us, "I have just used a meeting as group supervision for staff, staff are being supervised it is part of our action plan to improve." We found records of the group meeting dated 10 January 2017. This meant we could not be sure the spread sheet had been accurately maintained.

The registered provider had recently employed a clinical lead with responsibility for supporting nurses in the service with their revalidation and clinical supervision and competencies (revalidation is a process registered nurses must go through in order to evidence they remain competent to remain on the Nursing and Midwifery Council register.)The clinical lead had received their supervision from the manager and had records of competencies on file. We found two nurses had received their clinical supervision.

The manager advised that a visit from the speech and language therapy team had been arranged to train staff as one person who was returning to the service had experienced a change in need. This meant that staff would have up to date training to provide support to the person.

The registered provider employed a Therapeutic Services Team which consists of a Head of Therapeutic Services, positive behaviour support practitioners (PBS), therapy assistants, occupational therapists and a physiotherapist. PBS practitioners supported staff members to ensure they understood and were up to date with people's behavioural support plans. The team also held formulation meetings (used to determine how to support people following a behavioural incident) with staff members following any incidents so staff could debrief. We found these meetings covered triggers, strategies and outcomes for people. The therapy team were visible within the service. We saw staff approach them for support and guidance. We found records pertaining to occupational therapy input, along with physiotherapy assessments and reports. Health and social care professionals commented on the effectiveness of the team. One professional told us, "They use a personalised approach, there is a big difference with the therapy staff."

People were able to attend a breakfast club which offered a range of cooked breakfasts, cereal and toast. A microwave, toaster and kettles were available for people to use. We saw people preparing their own breakfast of cereal and toast. One staff member told us, "There are no set times, people can come and make their own. They are more independent that way."

We observed lunch time in one of the dining rooms. People were supported to sit where they preferred in the dining room. We observed meals were served before cutlery or condiments were made available for people. Lunch was a choice of lasagne and salad, pasta bake or fresh salmon and vegetables. Cold drinks were not available. One staff member asked another staff member to make some tea for people.

People enjoyed their meals in a relaxed atmosphere. Staff asked people if they wanted an apron on and staff explained what they were doing. For example, we heard staff say, "Can I just pop this on you to save your nice t-shirt? Is that okay?" Staff asked people if they wanted support to eat before doing so. One person needed full support to eat. We saw the staff member supporting them took their time and waited until they were ready before offering another mouthful of food.

People had mixed views about the quality of the food. One person said, "It's nice." Another person told us, "The food's okay." A third person commented, "The food is not good, it's not much cop. All the meat is stewed." A fourth person described the food as "disgusting", they told us food was "not properly cooked." One relative said, "I don't think the ingredients are that good." The kitchen was on the ground floor and despite being transported to the upstairs units in a heated trolley people told us the food was often cold and this was a recurrent problem. We spoke with the manager about people's comments. On the second day of the inspection the manager had spoken with the kitchen staff to ensure that the hot trolley was put in the dining room and then plugged in. We discussed the comments about food with the manager who advised they would speak to people about their comments to address their issues.

Each unit had a communal area for people to sit and watch TV. The areas were sparse with very little decoration. No consideration had been taken to make the areas more homely by using tamper proof decoration or safe ornaments. The manager advised that this was something they were keen to change as part of the improvement plan as well as enhancing the meal time experience for people. By ensuring people were supported appropriately and tables were set with table clothes, cutlery (where this was appropriate) and condiments.

People had access to health care when necessary. We found evidence of attendance to hospital, reviews by dieticians, psychiatrists and GP's. Staff were aware of up and coming appointments with external health care professionals. One person told us, "If I need to see the Doctor it's no problem, I just tell [team leader]."

Good

Is the service caring?

Our findings

When we last inspected the home we found the home was not always caring and the registered provider had breached regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Staff were not able to carry out specific instructions as set out in a care plan for people who needed splints to reduce the risk of contractures. Staff were not aware of the need or impact that could occur if the splints were not applied.

We found improvements in the knowledge of staff in how to support people. Staff were aware of how to apply splints and when to do so.

We asked people and relatives if they found staff to be caring. One person told us, "This is the best place I have been in." Another person told us, "It is nice here, I am happy here, I go out when I want to and have my [relative] to see me all the time." A third person told us, "Oh, they are lovely, can't fault a thing." A fourth person said, "A fourth said, "The staff are absolutely spot on. It's a home from home here. My family know how happy I am here. I love the company in here. The staff are so easy to speak to." A fifth person told us, ""The girls are nice. I like being here."

People's relatives were also happy with their family member's experiences of living in the home. One relative told us, "My [family member] has told me things have gotten better. They are absolutely fantastic, they give me support, there is definitely an improvement. They are caring, medicines are very important and they are on the ball with the timings, the same staff are on the unit, that's important."

Staff we spoke with were able to describe people's support needs in detail. For example, assisting in the hydrotherapy pool, support with PEG feeds and application of splints. One person gestured to us about their eating plan, staff were able to interpret what the person was trying to tell us. It was clear there was a rapport between them.

We observed staff engagement with people and found explanations and consent were given and sought before providing care, choices were offered, with dignity, privacy and independence promoted. One staff member told us, "It is far better for them to do things themselves, I would always help if needed." One person told us, "They (staff) always give me choices of what is going on. I have a lovely room which is just for me. I have all my own things and can close the door and be on my own if I want." We found people's independence was promoted by staff, people took part in cleaning their own rooms. One person had facilities to make toast and cups of tea which enabled them to welcome guests into their room.

Staff were respectful of people and each other. Staff knocked on people's doors before entering. We observed staff displayed a caring, kind and compassionate attitude towards people and visitors. We observed many positive interactions throughout the inspection, providing support with mobility, spending time in lounges to chat. Staff we spoke with knew people's life histories, needs and wishes. We saw people enjoying banter with staff. When one person said they were a bit cold one staff member turned the heating up. Staff used a privacy notice on people's doors when carrying out personal care to alert others.

We found people's rooms were personalised with posters and stickers on walls and doors. People had televisions, DVDs and CDs along with personal items on display. One person told us, "This is just how I like my room." Some rooms had the name of the person on the door, with instructions for visitors. For example, 'ask for permission before entering this room'.

The service provided a place for people to pray and where necessary support people to attend their chosen place of worship. Cultural and religious beliefs in relation to food were respected by the service. Information was available for people and visitors. The service had notice boards in communal areas highlighting the gardening group, activity schedule and the complaints procedure. The service had information available to people and visitors regarding advocacy.

Requires Improvement

Is the service responsive?

Our findings

When we last inspected the home we found the registered provider was not responsive and had breached regulations 9, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We found care records did not reflect people's current needs and on occasions missed important information about people's mental health needs. Staff were not following people's care plans in relation to specific interventions relating to skin integrity and diabetes. Risk assessments were generic and not personalised. The registered provider had not considered the adverse impact on people who used the service from inadequate records and a lack of oversight of people's care needs.

We found some care plans and risk assessments had been reviewed and updated and were more personalised. One person's care plan showed changes in the support provided by staff had reduced instances of behaviours that challenge. The person was experiencing less aggression and falls by using one to one staffing with more mature staff. Weight had increased by introducing finger foods and medicines were being accepted more due to them being changed to liquids. Another person's records showed they were responding well to challenging behaviour interventions, especially the use of visual aids which allowed better understanding. During the inspection they took us to the board containing the visual aids, this appeared to work well and improved their understanding of when things were happening which greatly impacted on their well-being. For example, when a new piece of furniture was arriving the white board contained a picture of it so the person knew it was coming.

We reviewed four care plans which were specific to medicines. We found they were not up to date or reviewed at the appropriate frequency as determined by the registered provider. We found that as required protocols had not been reviewed and updated when changes had occurred. This meant that there was a risk of inconsistent care and people not receiving care and support with medicines as required.

People had emergency care plans in place for incidents, along with the current external professionals to call on if necessary. For example, issues with PEG.

The Head of Therapeutic Services gave us an example of the new 'life star' which they had introduced. One person had this completed to date. The Head of Therapeutic Services told us, "This is something that we will be rolling out to others. I wanted to pilot it first in Deneside to make sure that this was effective for people here." We found a detailed record of the person's health, how they spend their time, how they are responsible and safe, their living skills, communication needs and people they know, how they manage money and letters. These were then plotted on a star graph in April 2016 with actions for each section. We could see from the life star that the person's health and well-being had improved when the review had taken place in November 2016. We found detail in the report from physiotherapy input, occupational therapy sessions and that an independent mental capacity advocate (IMCA) had been appointed. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions, including making decisions about where they live and about serious medical treatment options. We found the clinical notes from therapeutic services extremely detailed and personalised. For example, details of a bathing assessment with the occupational therapist and how advice was given to staff in supporting the person.

The service provided support to people to continue with interests and hobbies. The registered provider had developed activities over the recent months with the recruitment of two activity coordinators. We saw evidence of trips out to the local shops, the seaside, and the theatre. People using the service had attended a Christmas party hosted by the registered provider. Pictures of activities and the party were available for relatives and visitors to look at. One person, who would not normally attend such events, had been supported by staff to attend and had really enjoyed themselves. An activity scrap book was on display in the reception area which highlighted the activities which had taken place.

Staff prepared a weekly letter for one person's parent. This contained pictures of activities and details of how [person] had enjoyed the activity and how they were getting on. We found communication between the service, relatives and health and social care professionals was by way of emails. For example, 'thank you so much, you are doing wonders with him,' and 'I am so impressed, he looks so relaxed, happy and engaged, your team are just incredible.'

We saw posters advertising a new gardening club and a bingo tournament for people to attend in the future. The Head of Therapy Team told us, "The activities managers' role includes coaching the care staff to initiate spontaneous activities with residents to supplement planned activities." We observed one care worker supporting someone to make a poster to welcome visitors in the building.

Another person volunteers at a local wetland and enjoys walking. We found a room with resources for drawing, painting and craft activities. We were told there was a plan for day to day activities and found this on display in the reception area, but could not see anything displayed on the unit telling people what was on offer each day. We saw people attended sessions in the hydrotherapy pool, and baking. People could choose their level of engagement. For example, one person watched the cake making and another was involved in measuring ingredients.

The service had a complaints policy in place which explained how people should make a complaint and how that complaint would be handled and investigated.

We reviewed the complaints file and found that no formal complaints had been made since our last inspection in July 2016. During the inspection we spoke with a number of people who used the service who told us about the issues that they had raised since our last inspection. They told us they had also made some suggestions about how the service could improve and that they felt they were now getting better responses from the managers of the service.

Inadequate

Is the service well-led?

Our findings

When we last inspected the service we found the home was not well-led and the registered provider had breached regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The manager had not checked nurse's clinical competencies to ensure they were safe to provide care for specific health care needs. The manager had not taken people's individual assessed needs when developing staffing rotas. Quality assurance systems were not always effective in identifying issues and to demonstrate any improvements and actions were monitored.

The service did not have a registered manager in place. The previous manager had recently left the service before finalising their application with the Commission to become the registered manager. The service did have a peripatetic manager who was being supported by the Director of Nursing and Quality. The manager told us they intended to submit an application to become the registered manager of Deneside Court to support the service as it moves forward. This was a continuing breach of registration requirements.

We found the registered provider had ensured nurses' clinical competencies were completed for employed nursing staff and some regular agency nursing staff. However, we found some of the newer agency staff had no evidence of clinical competencies being checked or carried out by the registered provider. This failure to appropriately embed this action was a continuing breach of the regulation and meant that the registered provider was failing to meet, in full, the conditions of their registration.

At the time of the inspection we found the newly appointed Director of Nursing and Quality, and the Assistant Director of Nursing and Quality were both working within Deneside Court for the week. We spoke with both members of staff who told us that this was the first opportunity for them both to spend significant time together at the service since their appointments. They told us that they were at the service location all week in order to gauge what work needed to be done to improve the governance and quality arrangements. When we spoke about the improvements made since our last inspection they told us that no significant progress had been made or embedded but that plans had been developed as they recognised that work was needed to address shortfalls that had been identified in the previous inspection and also through the initial work that they had carried out within the service. The Director of Nursing and Quality told us, "My next step is governance and we know we have a long way to go but we will get there in time". They went on to say, "At the moment it is like I am setting the tracks ready to get up the hill". The Director of Nursing and Quality sent us further details of her plans following the inspection visit.

We asked to review the quality audits that had been completed since our last inspection in July 2016. We were told by one member of staff there had been nothing completed since July 2016. We asked to confirm this was factually accurate by reviewing the two audit folders that were present in the manager's office. We saw that one of these folders contained audits completed up to May 2016 and the second folder contained audits covering the period May to July 2016. Both the manager and the Director of Nursing and Quality told us that they had made efforts to determine if further audits had been completed and confirmed that no audits were available from July 2016 until their appointments.

The manager told us that since they had commenced employment they had completed four audits throughout January 2017. We saw that these audits included audits of the kitchen, infection control measures, health and safety and medications. We found that the medication audit that had been completed had failed to identify the issues found by our pharmacy inspectors. This meant that the audits reviewed were ineffective.

The registered provider provided a sample of four care plan audits completed and dated following the first day of the inspection. Action plans were in place with timescales where shortfalls were found in the care files. These audits had not picked up the lack of review of as and when required medicines administration that was found by the inspection team. This raised concerns around the effectiveness of the audits that were being implemented.

Following the last inspection the registered provider had been working alongside the local commissioning authorities to address the concerns that were raised within that inspection. This had resulted in an action plan being developed and agreed with the registered provider. We reviewed this action plan as part of our inspection and found that the action plan was not completed in full by the timescales that had been initially agreed.

The registered provider had acquired the staffing resources to begin to develop the necessary actions required to address the issues identified in the last inspection but had failed to implement and embed improvements to enable sustained and significant improvements.

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

At the last inspection we raised concerns around staffing levels and how they were determined. At this inspection we found that the registered provider had made the decision to introduce three units across the service all with dedicated staff. This meant that staff were not expected to move between units throughout the course of their shifts. Staff we spoke with told us that they no longer felt unsafe. We also found that the manager had started using a new dependency tool for one of the units. The output of this process demonstrated that the staffing levels were appropriate for the needs of people living within that unit. This tool had only been implemented on one of the three units across the home. The manager told us, "The dependency assessments will be reviewed and used to determine staffing levels using the new dependency tool." The manager advised this would take place by the end of February following staff training in the tool. This demonstrated that the registered provider had failed to take appropriate and timely action to address this area following our last inspection.

We saw that since the last inspection staff meetings had been set up to enable engagement with all staff across the service. For different staff groups meetings had been held in November 2016 and January 2017.Staff we spoke with spoke very positively of the manager, describing her as thorough, experienced, responsive and hard working. Staff described team work as having improved in recent months. One staff member told us, "I feel safe since the new management." Another said, "I have been here two years and the improvement since the last inspection is mega, you don't feel scared and the management is behind you." When speaking about the manager one agency worker told us, "No problem is too small, there are definite improvements over the last few months." They commented about how hard working and supportive the manager was, they considered her to be very approachable.

Relatives we spoke with felt there had been improvements. One relative told us, "If we mention anything, it's been addressed," They commented this had not been the case before the last inspection. Another said, "The

new manager is keen to put things right, no hidden agendas." Other comments made by staff included, "No longer fobbed off with excuses and there was more accountability from staff when dealing with problems, "and "We have meeting for families outside of Deneside now, I found that helpful."

We found that people and their relatives attended a 'My Say' meeting that was last held in October 2016. We found minutes were in pictorial form to support people with communication needs. We saw that six service users attended this meeting and were given the opportunity to put forward changes that they wanted and felt would benefit the service. We were also informed by the Director of Operations that a satisfaction survey had been sent to everyone using the service. This was done in an attempt to capture the views and opinions of everyone. At the time of the inspection the results of that survey were unavailable and as such we were unable to obtain any evidence of people's views from the carrying on of that survey.

The registered provider had recently developed a 'Friends and Family Group'. The group is for relatives and visitors to meet on a regular basis away from the service to discuss issues and concerns as well as hear about the registered provider's plans for improvement. The first meeting was held on the second day of our inspection, 2 February 2017. We were provided with the minutes of the meeting which suggested it was positively received. As this was the first meeting to have convened we were unable to reflect upon the impact this would have in sustaining improvements across the service.

Careline Lifestyles UK Ltd had been selected by the British Institute of Learning Disabilities (BILD) as one of only two care providers nationally accredited to 'deliver person centred active support' training. The institute works for people with learning disabilities to be valued equally, participate fully in their communities and be treated with dignity and respect by helping organisations who provide services. A certificate of this was on display in the reception area.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always act in accordance with the Mental Capacity Act 2005 by failing to recognise people's lasting power of attorney. Regulation 11 (1)

The enforcement action we took:

We took enforcement action but this did not proceed as improvements were made in relation to this breach of Regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to provide safe and proper management of medicines. The provider failed to assess the risks for service users in the event of an emergency. The provider failed to address areas of fire safety. Regulation 12 (2) (b) (2) (g) (2) (i)

The enforcement action we took:

We imposed conditions on the provider's registration and following an appeals process at the tribunal stage the Court imposed further conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not able to demonstrate effective governance arrangements. Regulation 17 (2) (a)

The enforcement action we took:

We took enforcement action but this did not proceed as improvements were made in relation to this breach of Regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure agency staff received appropriate on going or periodic supervision in their role to make sure they were competent and that competency was maintained. Staff were not receiving supervision in a timely manner. Regulation 18 (2) (a)

The enforcement action we took:

We took enforcement action but this did not proceed as improvements were made in relation to this breach of Regulation.