Gainford Care Homes Limited

Lindisfarne Newton Aycliffe

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 4 and 5 January 2018 and was unannounced. At our last inspection in October 2015 we rated the service as good and there were no regulatory breaches.

During this inspection we found breaches of Regulations 12, 15 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not done all that was reasonably practicable to mitigate risks to people including the safe administration of people's topical medicines and the cleanliness of equipment used in the home. We found wheelchairs in the home were not being used in a safe manner. The audits carried out failed to identify these issues and records were not always up to date and accurate.

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

Lindisfarne Newton Aycliffe provides accommodation for up to 56 people across three separate units. One of the units specialised in providing care to people living with dementia. At the time of our inspection there were 51 people residing in the home.

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

We found there were safe arrangements in place for the storage and disposal of people's medicines. People had been prescribed topical medicines (creams applied to the skin). Guidance had not been given to staff on the frequency topical medicines needed to be applied.

Whilst the home was clean and tidy throughout risks to reduce cross infection had not always been carried out. During our inspection the registered manager made arrangements to make improvements.

We observed wheelchairs were not being used appropriately. Foot plates were missing. The registered manager carried out an audit of the wheelchairs in use during our inspection to reduce the risks to people using the wheelchairs.

People had care plans in place which contained personalised information. These were reviewed on a regular basis.

The service had in place a number of audits for monitoring quality. These audits resulted in actions required to improve or sustain the service. We found some of the audits had not uncovered the deficits in the service.

Risk assessments were in place to manage the environment and people's personal risks.

During our inspection we reviewed seven staff files. We found the provider carried out robust checks on prospective staff members before they were permitted to start working in the home. Staff had received an induction and were provided with continuous support through training supervision and appraisals.

People were protected from the risk of abuse because the staff in the home understood their roles and responsibilities to keep people safe. Actions had been taken if staff were concerned a person was at risk of harm.

There were regular checks carried out on the building. These included fire checks and the monitoring of hot water temperatures to prevent people from being scalded. Checks were also carried out on beds and bedrails.

Kitchen staff understood people's dietary requirements and how to provide food to people who were at risk of losing weight. We carried out observations on lunchtime on each of the three floors. People who needed full support to eat were provided with the required support to eat at their own pace. People who needed their food cut up for them did not always eat their meal. Staff later encouraged them to eat food which would have gone cold. We recommended the service review the meal time arrangements.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The service had communication systems in place to ensure staff were aware of and kept up to date on people's needs. These included daily notes, appointment diaries and handover notes between shifts.

Staff spoke to us about people's personal preferences and were able to demonstrate they knew and understood people's likes and dislikes.

We found staff were alert to and responsive to changes in people's daily healthcare needs. Any changes were documented in a notebook for a nurse who regularly visited the home to review.

Activities were provided in the home. We found activities were advertised but did not take place. Following the inspection the regional support manager told us this was an error and the advertised activities should have been taken down. Staff told us they did not always have the time to support people with activities. A second activities' coordinator was due to start work. We recommended the provider reviews the delivery of activities in the home.

The provider had a complaints policy and procedure in place. Complaints which had been made about the service had been investigated by the registered manager. Complainants had received an outcome for their complaints.

The views of relatives about the service had been sought. These had been reviewed and the registered manager sent a letter out to relatives providing explanations and telling them what actions had been taken.

The registered manager reviewed the service and sent weekly reports to the regional support manager to demonstrate what actions had been taken to support people's needs.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Arrangements were not in place to ensure people's topical medicines (creams applied to the skin) were appropriately applied by staff.

Risk assessments were in place. For example the provider showed us care plans to demonstrate people were wearing slipper socks to reduce their risk of falls.

Regular checks were carried out on the building to ensure people lived in a home where fire risks were minimised.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always use wheelchairs in a safe manner. We found wheelchairs with missing footplates. The registered manager took action to reduce the risks.

People who needed full support to eat were encouraged to eat at their own pace. We observed other people who required intermittent encouragement and support were encouraged to eat by staff at a point when their food would have gone cold. We recommended the provider reviews the meal time arrangements for people using the service.

Staff were supported through induction training, supervision and appraisals to carry out their duties.

Is the service caring?

Requires Improvement

The service was not always caring.

During our inspection we carried out observations of staff interaction with people who used the service. We found some staff were caring towards people but saw other staff behaviour which was less than kind.

Staff supported people to be independent and encouraged people to use walking frames and sticks to walk independently.

Relatives told us they could visit any time they wished. We found some relatives who visited at specific times each day to be involved in their family member's care.

Is the service responsive?

Requires Improvement

The service was not always responsive

Information contained in people's care plans was person centred. However we found staff had not always followed guidance to keep people safe.

Activities were provided in the home. However we found during our inspection people were not always supported to participate. We recommended the provider reviews the delivery of activities in the home.

Complaints made about the service had been investigated by the registered manager and an appropriate response was given.

Is the service well-led?

Requires Improvement

The service was not always well led.

We found a number of areas for improvement in the home which had not been found or addressed when audits to monitor the quality of the service had been carried out.

Staff described to us an uncomfortable working atmosphere between groups of staff employed in the service. The registered manager was aware of the divisions in the staff team and had plans to address the issue.

A survey of relatives had been carried out. The registered manager had listened to the survey and had written to relatives to respond to the feedback.

Lindisfarne Newton Aycliffe

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 team consisted of one adult social care inspector, one specialist advisor to CQC with a background in occupational therapy 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. The expert by experience on this inspection had personal experience of caring for older people.

Prior to the inspection we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service; including local authority commissioners.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with17 staff including the provider, the regional support manager, the registered manager, the deputy manager, nurse, senior care staff, care staff and kitchen, domestic and maintenance staff. We spoke with three people who used the service and five relatives. We reviewed five people's care files and other information in relation to the regulated activities. We looked at seven staff files. We also spoke with two professionals who had contact with the service.

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

Requires Improvement

Is the service safe?

Our findings

In July 2017 the Infection Prevention and Control Team which is funded by the Clinical Commissioning Group had visited Lindisfarne Newton Aycliffe and found no improvements were required to the home in respect of cleanliness and infection control. During our inspection we looked around the home and found it was clean and tidy. Staff used personal protective equipment (PPE) to reduce the risk of cross infection. We looked at two mobile hoists and shower chairs. A hoist on one floor of the home was visibly dirty and the hoist legs and other lower parts had areas which were rusting. This means that the cleaning, decontamination and infection control arrangements were compromised. The registered manager arranged for the cleaning and repainting of the hoist and the cleaning of the shower chairs. They told us they had ordered one new replacement shower chair.

We saw hoist slings in people's rooms. In one room we found a sling smelt strongly of urine. Some slings had different room numbers and people's initials on them to the rooms in which we found them. This meant it was not possible to tell if the correct slings were being used for each person to reduce the risk of cross infection. We drew this to the attention of the registered manager who arranged for a sling audit to be carried out. Following the inspection the regional support manager told us the initials on the slings were of deceased residents, slings had been laundered appropriately and put back in use following assessments; staff had not changed room number and initials. This was therefore not a risk of cross infection but human error. The regional support manager told us the slings in each person's room matched with a record held in the care documents in the office. This was the registered manager's office on the ground floor. This meant staff working on each floor may not have been able to tell if the correct sling was being used for each person.

We looked at the management of people's medicines and found staff were trained in the administration of medicines. We checked people's medicine administration records (MAR) charts and found in most people's MAR charts there were no gaps. However we found in one person's MAR charts there was no signature to state they been given a weekly medicine in the last two weeks. We could not be assured the person had received their medicine as prescribed.

Staff told us there was no one using the service who had pressure sores. We looked at people's topical administration records (TMAR) and found these were incomplete. Guidance to staff directed them to apply, 'as required' or 'as directed' without giving them specific instructions. Following the inspection the regional support manager told us the registered manager had contacted people's doctors to advise it was not sufficient to write on a prescription use 'As directed' July 2017. However the prescribing directions remained unresolved.

During the inspection with the registered manager we looked in people's en-suite bathrooms and found topical medicines which had been opened but did not have a date of opening. We showed these topical medicines to the registered manager who confirmed there were no dates of opening.
We found there were no body maps in place to show staff where topical medicines were to be applied. On checking people's records the registered manager also agreed body maps were missing. Following the

inspection the provider sent us copies of four people's care plans which told staff about the creams to be applied. However the care plans did not describe the frequency. This meant staff were not given accurate guidance as to the administration of topical medicines.

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

One person told us, "I know what I take, I always get my medicine on time, I never have to ask for it." Medicines were stored securely in clinic areas where room and fridge temperatures were taken on a daily basis. Controlled drugs are vulnerable to misuse. The service had the appropriate arrangements in place to ensure these drugs remained secure. We carried out a check on the controlled drugs and found records matched the actual numbers of controlled drugs. Facilities for the disposal of drugs were in place.

There were risk assessments in place about the management of the home. These assessments included the use of hot water systems, portable appliances and work stations. Risk assessments were also in place where a person had an identified risk. Staff were given guidance in the assessments to reduce the risks to people. However, we saw people had risk assessments in place in relation to their mobility and possible falls. People on all floors were observed not to be wearing slippers or shoes. Some had bare feet, some were wearing socks and some people were independently ambulant. Footwear that is inappropriate or missing is identified as a risk in the National Institute for Clinical Excellence (NICE) guidelines reference number CG161 2013. We were concerned people were wearing fluffy socks which put them at risk of falling. Following the inspection the provider told us people were wearing slipper socks and sent us copies of people's care plans where the use of slipper socks were noted.

Accidents and incidents were routinely fed into the provider's electronic systems. This enabled the registered manager to have an aggregated analysis of when and where accidents took place in the home.

The service had personal emergency evacuation plans (PEEPs) in place for each person. Should the building need to be evacuated, emergency personnel had access to information about the assistance each person required to leave the building safely.

Regular planned and preventative maintenance checks and repairs were carried out. These included regular checks on the premises and equipment, such as fire, electrical and gas safety. The records of these checks were up to date. Regular water testing took place and we found water temperatures were within acceptable national guidance levels to minimise the risk of scalding. We saw the provider Gainford Care Homes was accredited within the Contractors Health and Safety Assessment Scheme (CHAS). The certificate said the provider had demonstrated compliance with and sound management of current health and safety legislation.

Staff were trained in how to safeguard vulnerable people. Incidents which had given rise to safeguarding concerns in the home were documented. Notifications had been made to the local safeguarding authority and to CQC. The provider had a whistle-blowing policy available to staff which explained how staff could raise concerns. This meant the home had embedded safeguarding practices in order to protect people.

The provider had a disciplinary policy in place to protect people from inappropriate staff behaviour. During our inspection we saw the provider and the regional support manager were carrying out an investigation into staff conduct.

We looked at staff recruitment records and saw that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two

written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. Documentation was completed to demonstrate staff were eligible to work in the UK. This meant the provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff, and on an on-going basis as necessary.

We spoke to the registered manager about lessons learnt. They told us they were always learning about individual people in the home for example through safeguarding incidents, and following a period of absence they had learned the home was able to continue to function with the skills and experience of the staff.

Staff rotas showed there was consistent numbers of staff on duty. We observed staff were constantly busy. One relative said, "Sometimes they (people who use the service) have to wait for things, it depends how busy it is at the time. There's always a member of staff in the lounge at all times." One staff member said, "Sometimes there's enough staff, it all depends on sickness and holidays, plus who you work with. If there isn't a good team on there isn't any routine." We found care staff reported to senior care staff on each floor. In turn senior carers were able to have access to the deputy manager or the registered manager for advice and support. On our inspection days we found there were enough staff on duty to provide supervision of people who used the service and meet their care needs.

Requires Improvement

Is the service effective?

Our findings

We checked the equipment in the home for safe use. Chair bath hoists were clean and had in date maintenance stickers. We observed the use of a hoist and found staff correctly used the hoist. However, the brakes on the wheelchair a person was transferred to were not put on. Brakes should always be on a wheelchair when stationary and during a transfer to prevent accidents.

We observed there were a number of wheelchairs in use and these were pushed by care staff which either had the footplates missing or turned to the side and not in use. This was not safe practice as the person using the chair could drag their foot on floor or get it caught in the wheels. Foot rests should be in use and adjusted to meet the user's leg length to support the weight of their lower legs and avoid discomfort and possible skin damage. The registered manager and staff on duty explained one person did not have footplates as they pushed themselves along using the floor. We observed however, a member of staff removing this person from another person's room and pushing them into the lounge without foot plates. We found risks associated with using wheelchairs had not been mitigated. Following the inspection the regional support manager advised the member of staff who was pushing the person felt their priority was to remove the person in the wheelchair from another person's room. We spoke to the registered manager about the wheelchairs. They arranged for an audit to be conducted and showed us their audited list of wheelchairs, some of which had foot plates missing. The registered manager told us they would make arrangements to address any missing footplates.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff encouraged and provided support to people to eat, enticing them with the offer of small portions to try to eat something. Staff had referred people to dieticians when they had lost weight. We saw people had been prescribed food supplements. We looked in the fridge in the bottom floor lounge and found Fortisips and Calogen shots with no names on them. One member of staff was unsure who they were for. Another member of staff told us the supplements had a cardboard wrapping and this had come off and they were able to tell us the person for whom the supplements were prescribed.

Staff kept food and fluid charts for people who were at risk of losing weight. Staff explained when people had reached a stable weight and were no longer considered at risk of losing more weight they no longer used food and fluid charts to monitor their intake. We found staff recorded people's intake but found for example target fluid intake was not always documented and fluid intake was not always totalled. We saw where one person had a low intake of fluids one day this did not generate actions for the following day to reduce the risk of dehydration and associated issues.

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

We checked the arrangements for meal provision in the home. Kitchen staff were informed by care staff of people's dietary requirements and were knowledgeable about people's needs. These were held within a folder in the kitchen. Kitchen staff we spoke with during the inspection had been trained in County Durham

and Darlington NHS Trust's 'Focus on Under Nutrition'. This is a training programme designed to support staff to prevent weight loss of people living in care homes. Staff were able to tell us about the course and how they had implemented their training in the home to reduce the risk of people losing weight. They also told us about how they provided meals for people who were diagnosed with diabetes.

We carried out observations on each of the three floors on lunchtime on the first day of our inspection. We found there were insufficient dining chairs and tables for people who lived on each floor to eat at a dining table. Staff told us some people preferred to eat in their rooms whilst other's preferred to sit in armchairs with small tables in front of them. We observed one person eating their meal which was placed on a small table in front of their comfy chair. They were at risk of weight loss and had to stretch out their arms to try to reach their plate of food with their fork. They lost interest in eating and only ate a small amount of their meal.

We saw people were given a choice about what they wanted to eat. People who needed full support to eat were assisted at an appropriate pace and allowed time to eat each mouthful. Staff told them what they had put next on their cutlery. However we found other people who needed food cutting up or who needed encouragement and support did not get it in a timely manner. For example we observed person to be turning an empty spoon over and over in their mouth. The person put the spoon to their bowl but did not get any food on it or the food would drop off before reaching their mouth. Eventually the person raised the bowl to their mouth but still had difficulty getting the food. Another person had a plate guard on their plate however the plate was turned the wrong way and they could not get the food on the fork. Other people whose food was cut up did not eat it and staff assisted these people to eat later when their food would have been cold.

We recommend the provider reviews the meal time arrangements for people using the service.

Profiling beds were in use throughout the home. A profiling bed can be adjusted to reposition and support people in need of additional support. We observed maintenance staff carrying out their monthly checks to see if the beds were in working order. The registered manager told us the maintenance person received a handover from another one of the provider's other maintenance staff on how to check the beds. They told us maintenance staff do not service the beds. We checked the beds for stickers which stated they had been serviced. Some of the beds did not have such stickers; others had stickers attached to the head or the foot of the bed. After our on-site inspection we spoke to the registered manager who told us some of the stickers were under the bed. The regional manager advised staff have reported to them if there is a fault with the bed and maintenance staff are called. They also said going forward they now have a contract in place to both supply and maintain profiling beds.

We found the provider had communication systems in place. A diary was maintained to document people's appointments and was also used to leave messages between staff for example to show when they had spoken to the pharmacy to obtain people's medicines or when their medicines were due to be ordered. Staff completed handover notes so pertinent information was passed between shifts and staff were up to date with people's care needs. This included staff knowing if people appeared to be coming down with a cold or had periods of agitation during a shift.

Staff new to the home received an induction. Staff were supported through supervision meetings and appraisals. A supervision meeting is a meeting between a staff member and their manager to include discussion items like their progress, their training needs and any concerns either party may wish to raise. The registered manager had a training matrix in place to monitor staff training. We saw staff had recently received training in moving and handling, basic life support, falls prevention and dementia awareness.

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 authorisation 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 staff had been trained in MCA and DoLS and understood what they were expected to do. Capacity assessments were on file and applications had been made to the local authority to deprive people of their liberty and keep them safe. CQC had been notified when these applications had been approved. Each person's file we looked at had capacity assessments in place. Consent arrangements were in place in the home. People had consent to receiving care from the service. Alternatively where a person was unable to consent relatives had signed people's care plans on their behalf.

The registered manager told us they had appointments booked to carry out assessments of people's needs and preferences before they moved into the home. We found pre-admission assessments were in place to see if the service could meet people's needs.

Staff reported to us there were divisions in the staff team which made it difficult to work effectively across the service. We discussed this with the management team who were aware of previous similar comments. Other professionals reported to us that relationships with them were good. Staff alerted other professionals appropriately and documented when other professionals had visited the home together with their advice. We found district nursing staff, community matrons attended the home on a regular basis. There were also visits for chiropodists, hairdressers and opticians.

Requires Improvement

Is the service caring?

Our findings

We found there were some staff who demonstrated they cared about people living in the home and other staff whose approach to people was not so caring.

Personal care took place behind doors to protect people's dignity. In one person's bedroom we found the name of a person who had passed away written on a duvet which showed through the duvet cover. We pointed this about to the registered manager who made immediate arrangements for the disposal of the bedding. They told us that, "Should never have happened."

During a lunchtime meal we carried out a Short Observational Framework for Assessment (SOFI). We observed one person sitting on their own and waiting for their meal. They were given their meal and then their desert. At no point were we able to ascertain the person's name through their engagement by staff. We observed a member of staff speak to them only to take them back to their room. We showed our SOFI findings with the registered manager who agreed that was unacceptable practice. We later spoke to the person who told us they had not had a conversation with a staff member that day. We observed other staff engaged people in conversation and chatted to people as they ate.

One member of the inspection team observed a member of staff supporting a person to eat. The person told the member of staff they could not see. The staff member muttered under their breath, "Well you are blind." We found this was unkind.

One person told us the staff are, "Considerate, treat me with respect." A relative said the, "Staff are lovely; they always have a good attitude, including the manager. They are lovely, very caring, I can't fault them." We found not all staff were respectful to people in the home. A member of the inspection team observed a person asleep with a newspaper in front of them. A member of staff removed the newspaper and said in a neutral tone to the side of the person, "You haven't read any if that." The person did not respond and we were unsure if they had heard the comment. We found this to be disrespectful. We observed conversations between staff took place in the communal areas. Staff members commented on people's appearance in front of them and others. One member of staff told a person in a loud voice they could not have the juice as they were, "Diabetic." We later found the juice provided was suitable for their dietary needs.

On other occasions throughout our inspection we observed staff kneeling down and talking to people face to face. Staff engaged people in meaningful conversations.

During the latter part of our inspection on day two we observed three people sitting at tables in the dining area. We observed one person being taken to the table by a relative after lunch. The three people were sitting in the same positions in which they were observed sitting at lunchtime at 4pm. One person was holding a small blanket to their face whilst another person had their head resting on the table. We spoke to the registered manager and expressed concern about how long people had been sitting in the same position asleep. The registered manager told us the people had been moved to go to the hairdressers and returned to the tables. We found staff left people to sleep at the tables without offering a more comfortable

alternative.

Arrangements were in place to hold meetings to involve relatives in the service. We saw these were poorly attended. People who used the service attended residents meetings. They were asked for their views about the food in the service and what activities they would like.

We asked about advocacy services in the home. Advocacy is where a person is supported to speak up, give their views and raise issues. At the time of our inspection there was no one using an advocate. Relatives had been engaged by staff as natural advocates for people to give their views about the type of care their family member needed. One relative we spoke with felt that had been listened to by the staff. Their relative was placed in a room where they could be observed by staff in the communal areas.

Staff were able to tell us about people's individual likes and dislikes. They knew and understood people's preferences. For example staff were able to tell us about people's backgrounds. The registered manager explained after their extended period of leave they had returned to find a number of new people to the home and were getting to know people as well as their visitors.

Relatives confirmed they could visit any time they wished. We observed relatives chatting to staff in an easy manner and exchanging relevant care information. Staff spoke to us about relatives who visited each day and were involved in the care of their family members.

During our inspection a number of people were suffering from colds and chest infections. We observed staff were sympathetic to their conditions and woke people up gently to try and engage them in eating and drinking. Staff spoke in gentle tones with one person and sympathised with them due to their lack of appetite. One person became distressed and disorientated in a corridor. Staff intervened and distracted them in conversation before guiding them to a more social area. This demonstrated staff were able to promote people's well-being.

People were supported to be independent. We saw staff encouraging people to walk independently, giving the support and telling them to take their time.

People's care files were stored in the manager's office and confidentiality was maintained. The registered manager told us staff could have access to people's care information at any time. Daily records were kept on each floor to enable staff to write frequent updates.

Requires Improvement

Is the service responsive?

Our findings

We found assessments which had been carried out prior to a person's admission to the home were used to develop their care plans. Care plans contained person centred information. This is information which is pertinent to each individual.

We found one person was cared for in a specialist chair. We found advice given by physiotherapists about their positioning in the chair did not take into account the risk of choking identified by the Speech and Language Therapy Team (SALT). Staff were aware of the risks but had continued to support the person to eat in a risky position. We raised our concerns with the registered manager who contacted a physiotherapist for further advice. Following our inspection we spoke to the registered manager who confirmed the physiotherapist had advised the person was repositioned in the chair to reduce the risk of choking. We found the service had failed to do what was reasonable to mitigate risks to the person.

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

People were assisted to communicate using aids. These were documented in people's care plans and we saw staff had supported people to have new glasses and hearing aids. We observed one person having difficulties in seeing what was in front of them and noted in their care plans they should be wearing glasses. We saw a magazine in front of them. We spoke to the registered manager who told us the person refused to wear their glasses and the care plans needed to be updated. The regional support manager told us following the inspection the person only wears their glasses for reading and sent us a copy of their care plan. We observed the person was struggling to see what was in front of them and staff did not seem to notice this or respond appropriately.

Where care plans identified a risk we found these had been followed up by staff. Advice had been sought for example from the Speech and Language Therapy team (SALT). The advice was incorporated into people's care plans. Care plans and associated risk assessments were reviewed on a monthly basis.

Daily records were maintained by staff. For example we saw staff completed food and fluid charts and behaviour charts. Information was also documented when other healthcare practitioners visited people. This included advice to staff on how to provide the appropriate care and treatment to people. Staff documented any health concerns in a book for a nurse who visited each day from the local surgery. We found staff were alert and responsive to people's changing health conditions. For example staff had written down that one person needed attention from the nurse as their eyes had become sticky. Early detection of health problems by staff prevents people's health deteriorating resulting in a possible admission to hospital.

We looked at the records appertaining to activities in the home. Activity records for each person included information on a person's background, their likes and dislikes. Records were kept that a person had participated in an activity, but not all the notes indicated what the activity actually was Some notes stated the person had participated in 1:1 but did not give details of what the activity was, how the person participated or how long it occurred. Other entries included where a person had gone out with relatives or

appeared to enjoy film. During our inspection we observed a person having their nails done and conversation being promoted between people in the lounge. One member of staff put on a sing-a-long DVD of a musical in a lounge. Some people were not positioned so as to easily be able to see the screen. Staff did not try to engage people in the singing. People were observed to be sitting around in the lounge asleep. During one afternoon we spent some time carrying out observations on one floor. People were sitting around or those who were ambulant had left the room after lunch. On the doors we saw a rolling programme of activities. The list included activities like dominos which we did not see taking place. The staff were busy doing notes. We asked them about the list of activities on the doors and who carries them out. Staff told us the activities are dependent on staff having the time. A second new activities coordinator was due to commence working in the home. Following the inspection the provider wished to point out that entertainers were provided for people and people were taken on outings. They told us the notice about the dominos should have been taken down and this was an error. We saw therapy dolls were in the sensory room, however these were not available for people to use.

We recommend the provider reviews the delivery of activities in the home.

We looked to see if information was accessible in the home. Information was provided on residents and relative's meetings. Activity information was not always accurate and there were no menus available to people on their tables on one floor. Staff provided them with a choice verbally. This meant people did not have information in accurate and readily available formats. Following the inspection the regional support manager told us pictorial menus were available in the home.

The provider had a complaints policy and processes in place. People told us they knew how to make a complaint. Complaints which had been made about the service were investigated and an appropriate response given to the complainant. Relatives we spoke with during the inspection told us they had not made any complaints as they felt it was not necessary.

During our inspection there was no one receiving end of life care. People had care plans in place which described their wishes. We found relatives had sent 'thank you' notes to the staff for the care and support they provided to people as they neared the end of their life. Relatives were complimentary about the support they had received from staff. In the registered manager's weekly reports we saw the service had worked in conjunction with local healthcare providers to put in place anticipatory medicines to ensure people were comfortable at the end of their life and experience a pain free death.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. After a lengthy period away from the service they had been back in their post for just over a month. During their absence the CQC had been informed of the temporary management arrangements for the home.

We found the provider had in place a system of regular audits to monitor the effectiveness of the service. Regional support managers carried out monthly audits to test the quality and regulatory compliance of the service. The support manager had listed actions to be carried out in the home including where the home needed to maintain current standards. Audits of people's care plans were in place. These audits identified where there were gaps in plans and action which were needed to make improvements. We saw staff had addressed the deficits. However we saw other audits had failed to identify the deficits we found in the service. For example the medicines audit had failed to identify the issues we found in relation to topical medicines. The infection control audit did not identify the issues we found in relation to the shower chairs and hoist.

We found improvements needed to be made to bring records up to date and ensure they were accurate. For example we found one person's medicine records included supplementary shakes. Staff had recorded these were to be given as and when required. We found staff had marked the medicine records as not required. The person had gained weight. The registered manager arranged for these to be removed from their medicines administration record. We found fluid charts needed to be fully completed by staff in order to monitor people's intake.

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

Other audits were regularly carried out by the registered manager or their delegated staff member. These included kitchen, bedrail and mental capacity audits. Audits specific to people who were newly admitted to the home or who were found to have a bruise were also undertaken.

Staff we spoke with described a culture of division in the staff team; they thought there were cliques in the staff group and were wary about talking to us when other staff members were present. We spoke to the provider, the regional manager and the registered manager on this issue. The registered manager explained they would be holding a staff meeting to address the concerns raised. After our inspection visit to the home we received anonymous whistle-blowing concerns about staff behaviour. We contacted the registered manager who provided assurances they had taken action.

We found the service promoted equality and inclusion within its workforce. Staff were employed from different backgrounds to support people.

Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We found the provider had made the appropriate notifications to the Care Quality Commission and they maintained a record in the home of these notifications.

The registered manager was required by the provider to submit weekly risk manager reports. These reports required each of the provider's managers to report on issues such as pressure sores, weight loss, safeguarding incidents and serious accidents or incidents.

The provider had in place a survey to monitor the views of people who used the service and their relatives. In their response to the most recent survey we saw people were complimentary about the service. Additional comments were invited from relatives. The comments included notable praise for the staff who were seen to be doing a difficult job and the registered manager. Other relatives commented on the need to improve communication, improve personal care in relation to people's glasses, hearing aids and hair and one relative wanted staff to take an interest in the people who used the service. Following the survey the registered manager wrote to the relatives to provide explanations and what actions they were taking to improve the service.

A staff survey had also been carried out in December 2016. Out of 61 staff only four responded to the survey. The staff responses had been aggregated. We saw the staff who responded were very positive about the service provided.

There were clear partnership arrangements in place with local health care services. A hairdresser visited the service on a regular basis.

The provider had sought external recognition to ensure their health and safety policies, systems and processes were up to date and met with national standards. They had sought a new contract to ensure the maintenance and safety of profiling beds.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to take all reasonable actions to mitigate risks to people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure equipment in the home had been properly maintained or used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes in the home were not effective in identifying areas for improvement.