

Gainford Care Homes Limited







Lindisfarne Crawcrook

Inspection report

Kepier Chare
Crawcrook
Ryton
Tyne and Wear
NE40 4TS
Tel: 0191 4137081
Website: www.gainfordcarehomes.com

Date of inspection visit: 5 August 2015
Date of publication: 07/10/2015

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	

Overall summary

This was an unannounced inspection carried out on 5 August 2015.

We last inspected Lindisfarne Crawcrook in April 2014. At that inspection we found the service was meeting all legal requirements.

Lindisfarne Crawcrook is a 60 bed care home that provides personal and nursing care to older people, including people who live with dementia or a dementia related condition.

A registered manager was in post. 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.

Summary of findings

People said they felt safe and they could speak to staff as they were approachable. We had concerns however that there were not enough staff on duty to provide safe and individual care to people.

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

People received their medicines in a safe way. However we have made a recommendation about some aspects of medicines management.

Not all areas of the home were clean and well maintained for the comfort of people who used the service.

Staff undertook risk assessments where required and people were routinely assessed against a range of potential risks, such as falls, mobility, skin damage and nutrition.

People had access to health care professionals to make sure they received appropriate care and treatment.

Lindisfarne Crawcrook was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People did not all receive a varied and balanced diet to meet their nutritional needs.

People said staff were kind and caring. However we saw staff did not always interact and talk with people when they had the opportunity. There was an emphasis from staff on supervision and task centred care.

There were limited activities and entertainment provided by the activities person. When they were not available, other staff did not provide activities for people to remain stimulated. Relatives we spoke with said more activities and stimulation needed to be provided for people.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to.

People said the manager was supportive and approachable.

The home had a quality assurance programme to check the quality of care provided. However the systems used to assess the quality of the service had not identified the issues that we found during the inspection to ensure people received individual care that met their needs.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Not all aspects of the service were safe.

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

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

Policies and procedures were in place to ensure people received their medicines in a safe manner. However we had made a recommendation about medicines management.

Checks were carried out regularly to ensure the building was safe and fit for purpose. The standard of cleanliness around the building was not satisfactory.

Requires improvement



Is the service effective?

The service was not always effective.

Staff were supported to carry out their role and they received the training they needed.

Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People did not all receive a varied and balanced diet to meet their nutritional needs. Special diets were catered for.

The building was not designed to meet the needs of people with dementia and it was showing signs of wear and tear in several areas.

Requires improvement



Is the service caring?

Not all aspects of the service were caring.

We saw there was an emphasis on task centred care with people as staff did not have time to spend talking with people or engaging with them.

People's dignity was not always promoted, especially in relation to meal times. We found people who lived with dementia were not helped to make choices and to be involved in daily decision making.

People we spoke with were on the whole complimentary about the care and support provided to people

Requires improvement



Is the service responsive?

The service was not always responsive.

Requires improvement



Summary of findings

Staff were knowledgeable about people's needs and wishes. Records did not always reflect the care and support provided by staff.

Staff in some areas of the home did not engage and interact with people except when they provided care and support. There were limited activities and entertainment available for people.

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

Is the service well-led?

Not all aspects of the service were well-led.

A registered manager was in place. Staff, relatives and other agencies told us they were supportive and could be approached at any time for advice and information.

The systems used to assess the quality of the service had not identified the issues that we found during the inspection. Therefore the quality assurance processes were not effective as they had not ensured that people received personalised care that met their needs in the way they wanted .

Requires improvement



Lindisfarne Crawcrook

Detailed findings

Background to this inspection

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

This inspection took place on 5 August 2015 and was unannounced. The inspection team consisted of an inspector, an expert by experience and a specialist nursing advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people. The specialist advisor helped us to gather evidence about the quality of nursing care provided.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send the Care Quality Commission (CQC) within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams. We also contacted health

and social care professionals who worked with the service. We received no information of concern from these agencies other than the local authority commissioners who told us the service was in default of their contract with regard to record keeping. They told us they were monitoring and planned to revisit the service to see if improvements had been made.

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

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 12 people who lived at Lindisfarne Crawcrook, ten relatives, two visiting health care professionals, the registered manager, the deputy manager, a registered nurse, eight support workers, an activities organiser, a domestic and two members of catering staff. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and all bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care plans for 11 people, the recruitment, training and induction records for four staff, six people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the registered manager completed.

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather their views. Other people who used the service said they felt safe. A person commented, "It's alright here." Most relative's also confirmed people were safe, however some people were concerned about staffing levels. A person told us, "I have to wait if I ask for anything. All I get is in a minute dear. So I don't ask for anything if I can help it." Relative's comments included, "It's a worry when we aren't here," and, "They need more staff because if (Name) falls they can't ask for help."

We had concerns there were not enough staff to meet people's needs in a safe, timely and respectful way.

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

Our observations and staffing rosters showed on the day of inspection and on some other days there were not enough staff to meet people's needs. The registered manager told us staffing levels were determined by the number of people using the service and their needs. Our findings did not support that people's dependency levels had been taken into account to ensure sufficient staff over the 24 hour period. At the time of our inspection there were 56 people who lived at the home who were supported by two nurses and nine support workers including one senior support worker who went off duty at 2:00pm. The worker who went off at 2:00pm was not replaced. Staff members commented, "Staffing levels need to be more flexible," and, "We need more nurses and carers."

Staff were particularly busy because of the needs of the people and the layout of the units. We saw most staff did not have time to engage with people apart from when they carried out tasks.

Downstairs 32 people were supported by a nurse, four support staff and a senior support worker until 2:00pm in two lounges. 23 people upstairs were supported by two support workers in one lounge and two support workers and a nurse in another lounge. These numbers also included people who were confined to bed. Some people required total assistance for their care and other people needed the support of two staff because of their moving and assisting needs. This meant when staff were supporting people others had to wait and they were also

unsupervised as staff were not always available to keep them safe. We intervened with a relative in the afternoon in the small lounge downstairs to provide assistance with a person. This was because the staff member who was on their own with seven people was not available to support the person, who we were told was at risk of falling, as they were busy with another person. We observed people had to wait for assistance as a staff member balanced supporting people who required urgent assistance with other needs such as being assisted to the lavatory. We also intervened at the lunchtime meal upstairs in one of the lounges to ensure people received hot food as they waited to be assisted with their meal. One staff member was responsible for five people who required assistance to eat, whilst the other staff member attended to three people who required assistance to eat in their bedrooms. The registered manager told us a member of support staff was off. However, even if the additional member of staff was available we had concerns arrangements were not in place to ensure there were sufficient staff on duty at all times to ensure the safety and personal care needs were met for all people who used the service.

We discussed with the registered manager, the inappropriate use of safety gates that were in place on some bedrooms on the unit for people who lived with dementia or a dementia related condition. We were told it was to ensure people who were confined to bed, but chose to have their door open, were not disturbed by people who may come in as they walked along the corridors. We were told people's relatives had given permission for these to be put in place to keep people safe. We considered this need to keep people safe in their bedroom should be considered as part of determining staffing levels rather than this form of physical restraint. The area manager told us they would look to purchase sensors that would be placed at people's doors, rather than safety gates. The sensor would trigger and alert staff if people went into bedrooms where people were confined to bed.

We were told two domestic staff were available each day from 8:00am to 6:00pm to maintain the cleanliness of the building. On the day of inspection only one member of domestic staff was working. We had concerns about the standards of hygiene in the building and the lack of suitable arrangements in place to cover when staff were

Is the service safe?

unavailable to work. Support staffing levels were insufficient to carry out domestic tasks as it reduced the amount of direct care and support provided to people who used the service.

We had concerns there was ineffective infection control and standards of hygiene within the home.

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

Not all areas of the home were clean. There was a malodour around the home. The corridor floors appeared dirty and handrails were sticky. For example, the main stair case handrail. Furniture, skirting boards and heater sills were sticky and marked in some bedrooms. The carpets in some bedrooms and communal areas were also marked and stained. The flooring in some en-suite and communal lavatories required replacement for effective infection control. For example, the linoleum around some lavatory pedestals was discoloured and lifting from the base.

Continence aids such as pads were stored in people's en-suite bathroom. Pads were stored on the shelf alongside the lavatory and in one en-suite we saw a soiled pad was left amongst unused pads. The registered manager told us they would expect people's continence aids to be stored in their bedrooms. We saw some soiled linen was left in the communal bathroom. The manager told us this would be removed. Some bins did not have a foot operated pedal to open the lid. We saw at lunchtime one staff member opened the pedal bin with their hand and then immediately afterwards took a meal to a person. In the main dining room there were a pile of dirty aprons beside the bin that were left from the breakfast and the lunch time meal. Paper towel bins in communal lavatories did not all have a foot operated pedal to open them and the lid needed to be lifted by hand. Other bins in some communal areas upstairs did not have a lid. The registered manager said that this would be addressed.

Staff had a good understanding of safeguarding and knew how to report any concerns. They were able to describe various types of abuse. They could tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. They told us they would report any concerns to the registered manager. Staff members comments included, "I'd report any concerns to my senior or the nurse in charge," "Me or the

nurse would ring the safeguarding team," "I think people are safe," "I did safeguarding training when I started work," and "I did safeguarding training with Gateshead Council." A staff member also showed us the safeguarding lines of reporting that were displayed on the notice board in the first floor office. Staff were aware of the provider's whistle blowing procedure and knew how to report any worries they had. One staff member told us, "The whistle blowing policy is in the staff handbook that you get when you start working here," and, "There is a whistle blowing policy in the policy and procedures file."

The provider had a system in place to log and investigate safeguarding concerns. We viewed the log and found 13 concerns had been logged appropriately. Safeguarding alerts had been raised by the home and investigated and resolved to ensure people were protected.

People received their medicines in a safe way. We observed medicines rounds on the two floors. Medicines were administered by the nurse for people with nursing needs and the senior support worker, who was responsible for administering medicines to people with non-nursing needs. We saw they checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. The staff administering medicines explained to people what medicine they were taking and why. They gave the person a drink with their tablets and then remained with each person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

We saw there was written guidance for the use of "when required" medicines, and when these should be administered to people who showed signs of agitation and distress. When required medicines are those given only when needed such as for pain relief. A health care professional told us, "I feel the senior members of staff possess a good knowledge base and continue to look for psychological interventions in dealing with challenging/distressed behaviours rather than using medicines to manage behaviours."

Medicines were appropriately secured in a locked treatment room. Medicines which required cool storage were stored appropriately in a fridge. The temperatures relating to the minimum and maximum temperature of the

Is the service safe?

fridge were recorded twice daily to ensure they were stored at the correct temperature. However, the temperature for the treatment room showed the temperature was 28 degrees centigrade for most days during July and August 2015. This meant the quality of medicines may have been compromised as they had not been stored under required conditions. The registered manager told us this would be addressed immediately.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs. These are medicines that require extra checks and special storage arrangements because of their potential for misuse. The registered manager and deputy told us that staff undertook a weekly check of stock balances. We saw this was not happening as in the last two months balances had been checked between every 11 to 21 days. This would therefore make it more difficult to track and identify when any errors had occurred.

Documentation for four people who required covert medicines showed the GP had authorised the decisions for the use of covert medicines, where people did not have mental capacity. However, the decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had not taken place with the relevant people that included the pharmacist. A best interest meeting involves care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests.

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and to keep people safe. They included risks specific to the person such as for falls, pressure area care and moving and assisting.

Regular analysis of incidents and accidents took place. The registered manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to distressed behaviour a person was referred to the behavioural team when a certain amount of incidents were recorded. A health care professional told us, "They (staff) manage a lot by themselves as they have the skills and support to do so, but they are always keen to seek help when necessary."

The registered provider had arrangements in place for the on-going maintenance of the building. Routine safety checks and repairs were carried out by the handyman such as for checking the fire alarm and water temperatures. However the fire log did not show that a regular visual check of fire-fighting equipment had taken place to show the equipment was available in case of fire. A regular visual check of the emergency lights had not taken place to show they were functioning in case of electrical failure of the main lighting. The registered manager told us they would speak to the handyman to ensure these checks were carried out regularly. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

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

Staff had been recruited correctly as the necessary checks had been carried out before people began work in the home. We spoke to one staff member who had been appointed in the past year and they told us that recruitment checks including two written references and a Disclosure and Barring Service (DBS) check was completed before they started work. The DBS provides information to potential employers about whether an applicant is debarred from working with vulnerable people and/or whether the applicant has previous criminal convictions. We looked at four recruitment records and saw checks had been carried out with the DBS before the staff member was employed. In addition, at least two written references including one from the staff member's previous employer were obtained. Documents verifying identity were also kept on staff records.

We recommended the registered manager considers the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs. Staff members comments included, "Yes, we get training," "I've done syringe driver training," "I've done training about mental health awareness," "We've had challenging behaviour training from the behavioural team," "I've done some management training," and, "I did train the trainer training so I can train staff."

The staff training record showed staff were kept up-to-date with safe working practices. The manager told us there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Training courses included, dementia care, distressed behaviour, nutrition, record keeping, communication and equality and diversity. Staff had also received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. However, the staff training matrix showed this needed to be updated for some of the staff team.

Support staff said they received regular supervision from the senior support worker every two months and nurses received supervision from the manager. Staff member comments included, "We discuss what's happening at the time, short term training and general issues," and "I get one to one support from the manager." Staff also received an annual appraisal to evaluate their work performance and to jointly identify any personal development and training needs. One staff member told us, "I had one earlier this year. We have them yearly and we discuss how the service functions, staffing issues and training and development."

We had concerns not all areas of the home were well-maintained and appropriately designed for the orientation and comfort of people who lived in the home.

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

We noted the building became very hot during the day and at times the temperature was 84 degrees Fahrenheit, some people complained they were too hot but other people did not want windows open. We saw some fans were available but they were not operational. The registered manager told us some larger fans would be obtained immediately. Some areas of the building were showing signs of wear and tear. Paintwork was scuffed and chipped on skirting boards and

doorways in some areas including corridors, communal areas and bedrooms. Some bedroom, corridor and lounge walls were marked. Not all bedrooms were personalised. Some appeared drab. In one bedroom we saw the person's belongings were packed in bags and pictures and photographs were waiting to be hung on their walls although they had been at the home sometime. Where relatives were involved we saw bedrooms were more homely. The plastic mattress protectors and pillow protectors on some people's beds were brittle and not conducive to providing people with a comfortable night's rest as they were noisy as people moved in bed. Some sheets were worn and discoloured in appearance. We saw towels were not available in people's en-suite bathrooms. The manager told us they had been taken to be washed after use in the morning and they would be available by the next morning. This meant people had no means of getting dried during the day.

We saw some bathrooms and a shower room were not tidy and where staff had finished showering a person a razor and toiletries were left in the communal shower room. We also saw toiletries and perfume left in a downstairs lavatory. As well as being untidy it was also a risk to people who lived with dementia, who may have tried to use the items without staff support. A relative told us a chest of drawers was stored in their relative's en-suite bathroom and they had to keep moving it out and into the person's bedroom. We advised they speak to the staff to check the reason why it was placed there.

We found not all of the premises were "enabling" to promote people's independence, and involvement. Corridors were dark and painted colours such as grey. Not all areas were well-lit. Hand rails were not painted a different colour to stand out from the background to help with people's orientation. People were unable to identify different areas of the home. There was no appropriate signage, doors such as lavatories and bedrooms were not painted different colours or signed for all people to identify the room and to help maintain their independence. We saw some corridors on the ground floor were decorated and had some pictorial displays to help people engage and be stimulated as they moved around, however those in place were worn and showing signs of wear and tear. There were no displays or themed areas of interest on the top floor corridor. The registered manager told us they had purchased some new chairs to create resting areas along the corridors.

Is the service effective?

We had concerns people did not receive a choice of menu and a varied diet.

This was a breach of Regulation 9 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

We checked to see how people's nutritional needs were met. We looked around the kitchen and saw it was stocked with frozen and tinned produce. We were concerned no fresh fruit was available and saw no fresh fruit had been ordered since June. The cook said this would be addressed. We saw an advertised alternative to the main course was not available at the lunch and evening meal to give people a choice. On the day of inspection the lunch was roast chicken and vegetables and chocolate cake and custard or soup and sandwiches. In one dining room staff told us they gave people who lived with dementia sandwiches as a starter and then the main course and pudding so they would have three courses at the meal time. People's comments included, "They always give me too much and I always feel poorly afterwards," "The food is awful, there is no flavour or choice," "There is never any fruit or salad," and, "The cook has no imagination, I don't want the same thing over and over again." The registered manager told us this would be addressed immediately.

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid balance' charts. The food charts used to record the amount of food a person was taking each day did not accurately document the amount of food a person consumed. For example, staff said they were recording portion sizes whereas the record referred to spoon sizes and numbers of spoonful's consumed. Fluid intake charts did not record the goals and there was inconsistent completion of the totals recorded. People were provided with drinks at meal times and at other times during the day.

The chef told us special diets were catered for. They told us they received verbal information from nursing staff when

people required a specialised diet. A formal record was not available in the kitchen to show changes that had been communicated about people's dietary requirements. The chef showed us a written record of people's food likes and dislikes that had been collected when they moved into the home, however it had not been updated since they moved in.

The chef explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and they explained how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. However when we checked the kitchen stores we did not see all the ingredients available to do this.

Records showed assessments had been carried out, where necessary for people's mental capacity to make particular decisions. For example, with regard to their health care.

CQC monitors the operation of DoLS. DoLS are part of the MCA. These are safeguards put in place to protect people from having their liberty restricted without lawful reason. We checked with the manager that DoLS were only used when it was considered to be in the person's best interests. They were aware of a supreme court judgement that extended the scope of these safeguards. We found as a result, that four applications were being considered and 15 people were currently subject to such restrictions. This meant people's human rights were being protected. The registered manager told us they were prioritising and dealing with new admissions as well as people who required constant care and support to keep them safe. They were aware that all people who lacked mental capacity would require an application to be processed by the local authority.

We were informed an application was made to the Court of Protection with regard to a person who needed support in relation to decision making. The Court of Protection will consider an application from a person's relative to make them a court appointed deputy to be responsible for decisions with regard to their care and welfare and finances where the person does not have mental capacity. A social care professional commented, "I found the staff were very informative when a client of mine was going through the process of a Court of Protection application and in need of support from health personnel."

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

Is the service effective?

range of health professionals. Staff received advice and guidance when needed from specialists such as, the community nurse, dietician, speech and language teams, psychiatrist and GPs. Records were kept of visits and any changes and advice was reflected in people's care plans. Comments from health care professionals we contacted before the inspection included, "Staff know their residents and their families and are attuned to changes and problems," "We have always found the staff to be receptive to the advice and guidance that we give them," "Staff are quick to respond to any changes in people's condition that may be related to ill health or a deterioration. They are always knowledgeable and up to date with any information regarding resident's care such as medicines and hospital visits," "When I was visiting I saw someone was in pain. The staff had already contacted the surgery and asked the GP to visit as well as giving them some pain relief," and, "Pretty good with referrals for us to go in, pretty red hot on seeking advice."

Staff told us they supported some people who displayed distressed behaviour. They told us they received advice and

support from the behavioural team. Healthcare personnel commented, "Staff seem to be able to handle the needs of people with distressed behaviour very well," and, "Staff are able to manage a number of our patients who are significantly challenging to care for. I have faith in their abilities and know that if they contact me about someone that their concerns will be valid and that they will have already tried their own problem solving."

People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so that staff were aware of the current state of health and well-being of people. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. The nurses told us a handover of verbal and written information took place between the nurses for each shift. Staff members comments included, "Handover lasts 15 -20 minutes, all staff attend, we review the daily records and the handover sheet is used as a prompt," "Communication isn't too bad," and, "We get information about how people have been at handover."

Is the service caring?

Our findings

Most people who used the service and relatives we spoke with were positive about the care and support provided. Relatives comments included, “I can’t fault the staff they’re brilliant,” “Staff seem very efficient, the care has been good so far,” “The care has been very good,” “The staff are very good,” “I have been more than happy with the staff, they are very understanding,” and, “The staff always seem to be happy here.”

We had concerns about some aspects of care people received.

This was a breach of Regulation 9 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

From our observations we considered improvements were needed to ensure that all staff interacted with people at all times, and not only when they carried out care and support with the person. We saw staff did not take the opportunity to engage and interact with each person and encourage their awareness and interest in their surroundings. We saw people sat sleeping in lounges for much of the time. On the ground floor although some staff were sometimes sitting supervising people, they did not engage with them. They did not take the opportunity to talk to people and spend time listening to what they had to say. We observed some people also remained in their bedrooms without stimulation and staff did not spend time with them except when they took meals and carried out tasks with them. When staff members were in the small lounge upstairs they talked with some people who were there.

Most staff engaged with people in a calm and quiet way. When they carried out tasks with the person they bent down as they talked to them so they were at eye level. Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people’s needs and preferences which showed they knew people well. Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person

to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

People’s dignity was not always respected. We observed that people did not always look clean and well presented. We observed relatives attended to their relative when they visited for example, combing the person’s hair, cleaning a person’s glasses and another relative said, “(Name) has no teeth in.” We also intervened to point out to a staff member about a person who was wearing a soiled jumper. Some relatives told us people did not always wear their own clothes. One relative commented, “Sometimes (Name) is wearing someone else’s clothes,” “(Name)’s laundry sometimes goes missing.” We observed a number of people did not wear slippers or shoes but had only socks on their feet.

People’s privacy was respected. We saw staff ensured any personal care was discussed discretely with the person. A person’s care plan also stated, “Wants to be attended to by a female member of staff only.”

We observed the lunchtime meal in the three dining rooms. The dining experience was not well organised. Tables were not set with tablecloths, condiments and napkins. Specialist equipment such as cutlery and adapted colourful dementia care crockery was not available to help people, who were able to maintain some independence as they ate their food. We saw people who lived with dementia were not encouraged to make a choice or be involved in decision making with regard to their food. Menus were not available in writing or any other format. For example, pictures or photographs if people no longer understood the written word.

We observed in the downstairs dining room that the atmosphere was calm and quiet as people ate lunch. Staff did not spend time observing whether people needed help during the meal, they stood at the hatch and talked amongst themselves when they had finished assisting anyone to eat. We saw one person tried to attract staff’s attention to complain about why their plate had been cleared away before they had finished. Another person tried to eat their pudding with a knife. Some staff did not interact with people as they served them and placed their

Is the service caring?

food down without saying what it was or acknowledging them. When food such as the soup and custard was very hot staff did not warn people that the food was hot and to take care whilst eating it.

In one of the upstairs dining rooms the atmosphere was not calm and tranquil to encourage people to eat as loud 'rock and roll' music played. The tablecloths were marked and condiments were not available. One staff member was available to assist five people who required full assistance to eat their meal and two people who ate independently. The other staff member assisted three people in their rooms. The meal time was not organised to ensure people received hot food. We saw the hot trolley that transported meals to the two dining rooms did not remain there to store the food until it was needed, some people waited for over thirty minutes to be served and the food was not hot. Jugs of pureed food were used by one dining room and when a staff member from the smaller dining room came to collect them they were told they were not finished with but would be brought along when they had finished. The jugs of pureed food and gravy were not kept hot in the meantime. The meals for people who needed assistance to eat were plated and covered with paper kitchen roll until staff were ready to assist that person. We saw the puddings were also served and left uncovered until the staff member was available to support the person. We intervened as we saw the food was not served in a timely manner and it was cold for the last people waiting to be assisted with their lunch. More hot food was provided by the kitchen. The registered manager told us a hot trolley should have remained upstairs but it could not be used in the small lounge as the plug was not suitable. The chef told us a

special plug had been obtained as previous plugs had blown the fuses. The registered manager informed us after the inspection that side servers had been ordered to keep food hot in the upstairs dining rooms.

Not all communal areas contained items of interest to help people relax or remain involved and aware of their surroundings. We saw no pictorial aids or orientation aids, such as activity boards, calendars, clocks, newspapers, magazines or books to help remind people of the date and time. This meant people were not helped, by their environment, to remember and be mentally stimulated.

Most family members told us they were kept informed about any changes in their relative's condition. Relative's comments included, "The staff seem very efficient and keep me up to date with any changes," and, "Staff keep me informed when I visit." We witnessed the reaction of one family when they visited and saw their relative, "Oh no look at their face, they've had another fall and they've a black eye." They told us they had not been informed. We discussed this with the deputy manager who told us it had happened two days previously and they would check why the person on duty hadn't informed the family.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision themselves. For example, an emergency health care plan was in place for a person that showed a "best interest" meeting had taken place with the person's family and the GP. The care plan detailed the "do not attempt resuscitation" (DNAR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

Is the service responsive?

Our findings

People commented there were limited activities and entertainment. Relative's comments included, "(Name) needs more mental stimulation," "There's an activities organiser, but people need more conversation." Comments from a recent satisfaction survey sent out by the provider also included comments such as, "Residents do not appear to be stimulated during the day," "Activities do not appear to take place as frequently as stated," "I haven't seen a lot of activities but (Name) probably wouldn't participate anyway."

We had concerns that people did not receive stimulation and they were not all offered a choice of activities to take part in.

This was a breach of Regulation 9 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

We spoke with the activities organiser and looked at their records. They told us they were employed 30 hours a week and were also involved in providing care and help to people at mealtimes. The activities record showed activities were mostly one to one and we observed the activities person painting with a person in the downstairs lounge. We were told a mini bus was available and people had the opportunity to go out when the handyman was on duty to drive the bus. The activities person also said people were supported to go out. However, a relative commented, "(Name) has not been out since they came here two years ago." We were told the hairdresser visited regularly and a church service also took place monthly. We did not see a programme of daily activities advertised which could have taken place when the activities person was not on duty. A support worker said, "We do activities when we've completed our paper work, but paperwork takes a long time."

In the lounges, which accommodated some people who lived with more severe dementia or cognitive impairment, there were no activities available to stimulate people. People did not have the opportunity to move from their seat as meals were served to them in their chair. We saw care was task centred rather than person centred. This meant support workers carried out tasks with people rather than attending to them at a time they may choose or spending time sitting interacting with people.

We had concerns that records did not all accurately reflect people's care and support needs with guidance for staff to deliver care and support in the way the person wanted.

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

Records showed people's needs were assessed before they moved into the home to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort.

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in people's needs. For example, the dietician was asked for advice with regard to nutrition. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. This was necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

Records showed that monthly assessments of people's needs were carried out. For example, with regard to a person's nutritional needs and falls. These needs were transferred to people's care plans which were updated and altered as people's needs changed. One person's records showed they had been admitted to hospital earlier in the year but their care plan had not been updated to reflect any change in their nutritional requirements. Staff and relatives were aware of the person's needs and other records showed how the person was improving. A relative told us, "Staff have helped (Name) to walk unaided again, and their speech has improved." The person said, "Staff have helped me to get my confidence back."

Staff knew the individual care and support needs of people, as they provided the day to day support. Care plans provided details for staff about how the person's care needs were to be met. Not all care plans gave instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They did not detail what the person was able to do to take part in their care and to maintain some independence. For example, "When prompted (Name) is able to carry out

Is the service responsive?

hygiene tasks unaided but sometimes needs encouragement and reassurance to complete the task, and, “To support (Name) to maintain a good level of hygiene and dress appropriately.”

Some people with distressed behaviour were referred to the behavioural team when more advice and specialist support was needed to help support the person. This advice was incorporated in some people’s behavioural plans to help staff provide care to the person. However, care plans were vague, for some other people who may show agitation or distress. For example, a care plan stated, “Can be resistive and verbally challenging.” The care plan did not give staff detailed instructions with regard to supporting the person. Information was not always available that included what might trigger the distressed

behaviour and the staff interventions required. This would help ensure staff all worked in a consistent way with the person to help reduce the anxiety and distressed behaviour.

People said they knew how to complain. The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained and we saw three had been received and they had been resolved or were in the process of being investigated. After the inspection we received a complaint which was referred back to the provider for investigation. One relative said, “I’ve been more than happy with the staff, they are very understanding, I cannot complain.”

?

Is the service well-led?

Our findings

A registered manager was in place who had applied to continue their registration with the Care Quality Commission in July 2013. The registered manager had been pro-active in submitting statutory notifications to the Care Quality Commission, such as safeguarding notifications, applications for Deprivation of Liberty Safeguards and serious injuries.

We had concerns the audit and governance processes had failed to ensure satisfactory standards were maintained.

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

Records showed audits were carried out regularly and updated as required. Monthly audits included checks on, documentation, staff training, medicines management, accidents and incidents, infection control, nutrition, skin integrity, falls and mobility. Although records were audited monthly and included checks on care documentation and staff management, these audits had not highlighted deficits in certain aspects of record keeping such as care planning to ensure the care plan contained detailed guidance so people received care in the way they wanted and needed.

Daily and monthly audits were carried out for health and safety, medicines management, laundry and maintenance of the environment. However the environmental audit was not always effective as it had not ensured that all areas of the building were decorated and had a good standard of cleanliness and infection control. The medicines audit had not highlighted the irregular checks of controlled drugs in the previous two months. We did not see evidence that an activities audit took place of activities records. This would have shown the gaps in recordings due to the limited activities available.

A financial audit was carried out by a representative from head office annually.

The registered manager told us monthly visits had started to be carried out by the area manager to check on the quality of care being provided by the service. These were carried out to ensure the care and safety of people who used the service. The area manager told us and we saw documentation for the new auditing system that was being

introduced which showed the frequency of the audits and depth of audit. We were also told by the registered manager that a dining and sleeping experience audit was to be introduced as a result of findings from the inspection.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people. We saw copies of the surveys of the quality assurance audit for 2015 which had been sent out to everyone in the service, we were told 23 responses had been received. The manager told us the results were analysed by head office. We saw findings from the survey corroborated our findings at inspection with regard to activities, cleanliness and food as they did not score as highly as other domains.

Nurses and support staff said they felt supported and could approach the manager at any time to discuss any issues. Staff comments included, "I feel supported, the manager is very approachable," "I can speak to the manager." Relative's comments from the provider survey of May 2015 included, "The manager is always approachable and helpful in any situation," and, "All staff and management are friendly and welcome us all taking time for us."

The service worked well in partnership with other agencies to help make sure that people's needs were met. Comments from other agencies included, "I have always had good professional relationships with the manager. I have found them to be approachable and understanding," "The registered manager is approachable and professional, they agreed to the task I requested," "We have developed a good relationship with the manager," and, "We have always found staff to be friendly and approachable and follow any instructions that we give."

Staff told us regular meetings took place and these included general staff and nurses meetings and daily department meetings. They were held to keep staff updated with any changes within the home and to discuss any issues. Meeting minutes showed recent meetings had discussed communication within the home, staff performance, the environment, cleanliness, people's care and record keeping.

Relatives told us meetings were held for people and relatives. Two relatives were unaware of the meetings. We

Is the service well-led?

saw meeting minutes from May showed two relatives had attended. The registered manager had identified this in the meeting and was looking to review the frequency of the meetings to help encourage people's attendance.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing
Staffing levels were not sufficient to look after people in a safe, timely and respectful way. Regulation 18(1)

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
The registered person had not ensured, in relation to the premises, they maintained standards of hygiene and infection control appropriate for the purposes for which they were being used.
Not all areas of the home were well-maintained and appropriately designed for the orientation and comfort of people who lived in the home.
Regulation 15 (1)(c)(e) (2)

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
Where meeting a service user's nutritional and hydration needs, the provider had not had regard to the service user's well-being.
The provider had failed to enable and support relevant persons to make, or participate in decision making.
The care and treatment of service users was not appropriate and, did not meet their needs and preferences.
Regulation 9(1)(a)(b) (c)(3)(d)(i)

Regulated activity

Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The registered person had not ensured systems and processes were established and operated to ensure compliance with the registered persons need to: assess, monitor and improve the quality and safety of the service; assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk, maintain an accurate, complete and contemporaneous record for each person; evaluate and improve their practice.

Regulation 17 (2)(a)(b)(c)(f)