Cleveland Alzheimer's Residential Centre Limited

Kirkdale

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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected Kirkdale on 1 November 2017. The inspection was unannounced. This meant that the staff and provider did not know we were coming.

Kirkdale is a single storey purpose built nursing home registered to provide care for a maximum of 38 people. At the time of our inspection there were 28 people using the service, all of whom were living with a dementia. The service was separated into two areas, Lavender accommodated those people who were more mobile and independent. People who required a higher level of support were accommodated on the Rosemary section. There was a spacious dining room for each area and a number of communal seating areas and lounges.

At the last inspection on 5 January 2016, the service was rated good. At this inspection we found some areas remained good however others required improvement.

The provider did not have a registered manager in place at the service. The position had been vacant since the previous registered manager's contract ended on 18 August 2017. The provider had appointed an acting manager to oversee the day to day running of the service, however, at the time of our inspection no candidates had been interviewed for the permanent role.

Quality assurance checks and audits undertaken to monitor service delivery were not always effective and had not identified the issues we found during our inspection.

The service was in need of refurbishment and redecoration. The environment had some dementia friendly adaptation but this was in need of improvement to ensure all areas of the service reflected best practice. We have made a recommendation about this.

There were areas of malodour around the service, some areas were in need of deep cleaning and there were no hand washing facilities in dining areas. We have made a recommendation about this.

At mealtimes people were given sufficient to eat and drink but were not fully supported to make choices about their food. We have made a recommendation about this.

Staff had completed training in safeguarding vulnerable adults and understood their responsibilities to report any concerns. Appropriate recruitment procedures and pre-employment checks ensured suitable staff were employed. Risk assessments relating to people's individual care needs and the environment were in place and reviewed regularly.

People's medicines were safely stored, correctly recorded and administered as prescribed by trained staff.

Staff received appropriate training and support. Training in equality and diversity was completed by all staff.

Staff supported people in the least restrictive way possible in line with the principles of the Mental Capacity Act 2005 (MCA). Where people's freedoms were restricted this was done following best interest assessments and the correct authorisation was obtained. People's health and wellbeing was supported by appropriate access to healthcare professionals such as community matrons, the falls team and the dietician.

There was a calm atmosphere around the service. People were at ease with staff and relatives told us staff were caring. Staff treated people with kindness and compassion.

Staff demonstrated an understanding of people's needs and how they liked to be supported. People's religious and cultural needs were considered and access to religious support was available regardless of faith. Care plans were well organised, detailed and specific to people's individual needs.

We saw people enjoying a musical afternoon activity however the activity co-ordinator only worked at the service for two days and we did not see evidence of activities taking place on a regular daily basis. We have made a recommendation about the organisation of activities.

Complaints were investigated in line with the provider's policy.

Relatives and staff felt the service was well managed. Staff described the acting manager as approachable and said there was an open culture. Records were well organised and easily accessible. Quality assurance checks and audits were undertaken to monitor service delivery.

One breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was found during this inspection. You can see what action we told the provider to take at the end of this 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.

Infection control systems needed to be reviewed and improved upon.

Staff knew how identify and report safeguarding concerns and knew how to use the whistle blowing procedure.

There were sufficient staff to meet people's needs.

The provider had effective recruitment procedures in place.

People received their medicines in a safe and timely manner.

Is the service effective?

Requires Improvement

The service was not always effective.

The environment was not fully dementia friendly.

People were not given sufficient support to make choices at mealtimes.

The majority of staff training was up to date. Some staff were overdue an update to their dementia training but this had been booked.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness, dignity and respect.

Relatives felt welcomed into the service and involved in their loved ones care.

Is the service responsive?

Good

The service was responsive.

People's needs had been assessed and personalised support

plans had been developed.

People's relatives were invited to be involved in preparing and reviewing care plans.

People knew how to complain and previous complaints had been investigated.

Activities required better organisation on the days the activities co-ordinator did not work.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not have a registered manager in place.

Quality assurance checks and audits undertaken to monitor service delivery were not always effective.

Relatives found the acting manager approachable and staff felt well supported.

The manager understood their responsibilities in making notifications to the Care Quality Commission.

Kirkdale

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 1 November 2017 and was unannounced which meant the provider did not know we would be visiting. The inspection team was made up of one adult social care inspector, an inspection manager, a specialist professional advisor and an expert by experience. A specialist professional advisor is someone who has a specialism linked to the service being inspected, in this case a nurse. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We also contacted the local authority commissioners for the service, the clinical commissioning group (CCG) and the local Healthwatch to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spent time with people living at the service. We spoke with eight people who used the service and nine relatives. We also spoke with the chief executive officer, acting manager, deputy manager, two nurses, six care assistants, the chef, three members of housekeeping staff and a person on work experience at the service.

We reviewed six people's care records and six staff files including recruitment, supervision and training information. We reviewed medicine administration records for people as well as records relating to the management of the service.

Due to the complex needs of some of the people living at Kirkdale we were not always able to gain their views about the service. We used the observations around the service to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We looked at cleanliness and hygiene around the service. Some bathrooms were untidy and in need of deep cleaning. There were no hand washing facilities in the dining room and no hand sanitizer was available in these areas for staff who were serving food and supporting people to eat. There was significant malodour around the service despite many open windows. The service was in need of refurbishment. Carpets were worn, paintwork needed refreshing and fixtures and fittings in the bathroom areas were 'shabby'. We fed this back to the acting manager and chief executive officer who acknowledged the issues and assured us they were looking at ways to improve the environment.

We recommend infection control systems are reviewed and improved upon in line with best practice guidelines.

Relatives told us they felt their loved ones were safe living at Kirkdale. One relative said, "[Family member] is secure here and well looked after." Another told us, "There have never been any slips, or trips, or falls all the time [family member] has been here." A person who used the service told us, "It's very nice here."

Staff told us how they kept people safe. One member of staff said, "I would feedback immediately if I felt anyone wasn't safe. If I think someone's needs have changed and they might benefit from one to one care I would speak to the manager. We have to keep people safe."

Staff had completed training in how to protect people from abuse. Protecting people from abuse was also routinely discussed during staff members' one-to-one sessions with management. This meant staff were frequently reminded of their responsibilities to keep people safe and how to report any concerns.

Staff understood the need to report any concerns to the management team without delay. Staff told us they had confidence in the management team to deal with safeguarding issues promptly and effectively. One member of staff told us, "I know what I need to report and how to report it. I would go to my nurse in charge first of all, the nurses are great and I know they would take the right action but I would be happy to go to [acting manager] if I had to."

Records showed safeguarding concerns were recorded and dealt with appropriately with referrals made to the local authority and notifications sent to CQC. We saw evidence that appropriate action had been taken by the acting manager to reduce the number of safeguarding incidents at the service.

We reviewed recruitment files for three staff who had begun working at the service since the last inspection. A thorough recruitment and selection process was in place. This ensured staff had the right skills and experience to support people who used the service. Background checks included references from previous employers and a Disclosure and Barring Service (DBS) check. DBS checks help employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people.

The acting manager used a dependency tool to calculate safe staffing levels based on the needs of the

people using the service at the time. Throughout the day we observed there to be enough staff on duty to meet people's needs quickly and keep them safe. A relative told us, "I visit five times a week and there are always plenty of staff at all different times of day."

There were effective risk management systems in place. These included risk assessments around people's individual care needs such as nutrition, pressure damage and falls. The Malnutrition Universal Screening Tool (MUST) was being used to assess people's risk of malnutrition and where concerns were identified people were being weighed weekly. Control measures to minimise the risks identified were set out in people's care plans for staff to refer to and these were reviewed on a regular basis.

Risk assessments relating to the environment and other hazards, such as fire and food safety were carried out and reviewed regularly. Each person had a personal emergency evacuation plan (PEEP) which contained details about the support they required to be safely evacuated from the building in an emergency. There was a short summary of peoples care needs attached to every PEEP so if temporary placement in another service was needed following an emergency, care staff would have access to essential information. Regular fire drills were recorded and we were informed that new drills including different scenarios were being introduced following feedback from a fire safety audit. The acting manager was proactive in ensuring people's safety and had moved one person to a room nearer a fire exit after identifying them as having higher level of risk when it came to emergency evacuation.

Regular maintenance checks and repairs were carried out. These included daily, weekly, quarterly, and annual checks on the premises and equipment, such as fire equipment, water temperatures and hoists. Other required inspections such as gas safety and electrical hardwiring had also been done. There were some gaps in records from the beginning of September 2017. The acting manager told us the maintenance person had left at this time but a new member of staff had been appointed and was undergoing induction training at the time of our visit. In the interim period checks had been done by the maintenance person from another service but the gaps had occurred when they were ill.

Accidents and incidents were recorded accurately and analysed regularly in relation to person involved, date, time and location to look for trends. Where patterns were identified action was taken such as referral to the falls team.

The arrangements for managing people's medicines were safe. Medicine records we checked had been completed accurately. Medicines were stored securely and checks were in place to ensure they were stored at the correct temperature. Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Records relating to controlled drugs had been completed accurately.

Instructions were in place for the majority of medicines prescribed to be given when required (PRN). However, two people did not have these PRN protocols in place and those in place had not been reviewed regularly. We highlighted this to the nurse on duty and they acknowledged the error and began working to rectify it immediately.

Staff who administered medicines had completed up to date training and their competency was checked regularly. We observed a medicines round and saw the nurse administered medicines correctly and secured the trolley safely during the round.

Requires Improvement

Is the service effective?

Our findings

We observed the lunchtime experience in both dining rooms. Meals were plated up from a hot trolley in the dining rooms. The food looked and smelled appetising but everyone was given the same meal without being asked what they would like on their plate, such as vegetables, gravy etc. Staff told us that alternative menu choices such as sandwiches, toasties and jacket potatoes were available but we did not see people being offered these. One person refused to eat their meal despite encouragement from staff and a nurse told us the person was prescribed fortified drinks due to poor appetite. A person with dementia may have problems communicating that they don't like the food they have been given so showing people an alternative dish or using prompts and pictures could encourage healthy nutrition. We observed one person repeatedly ask for a glass of water but being given a cup of tea instead which was further evidence that choice was not promoted at mealtimes.

Staff supported people in a calm and patient manner. We observed some people were quite agitated and challenging but despite our presence staff remained composed and handled the situation well. We did see one member of staff sitting with two people who needed assistance with their meal and helping them both simultaneously. This practice is not person centred or dignified and staff should be better deployed at lunchtime to avoid this.

We recommend that the service seek advice and guidance from a reputable source, about supporting people with dementia at mealtimes.

Relatives we spoke with were satisfied with the support given at mealtimes and the quality of the food provided. One relative told us, "The food is adequate although it's never cordon bleu." Another relative told us, "The care here is good, the staff help [family member] to eat every day, they also give [them] a fortified diet."

The décor around the service did not always reflect best practice in dementia care. Corridors were all painted in pale pastel shades that could not be easily differentiated from one another. Grab rails were painted in a very similar colour to the walls meaning they did not stand out visually. No contrasting colour was used on light switches, bathroom or bedroom doors. The Department of Health, Health Building Note 08-02 Dementia-friendly Health and Social Care Environments (March 2015) states; The use of colour and the layout of the buildings, can make an enormous improvement in people's quality of life, and can reduce the impact of their dementia and help them live more independent lives. The correct colours, textures and layout of the buildings can help to reduce confusion, isolation, and anxiety, and help people live well with their dementia.'

We saw that some communal lounge areas had been decorated in a dementia friendly way with some reminiscence items and visual and tactile items to engage people. We were told that staff had come in during their own time to decorate these areas. There was a good sized secure garden and we were told people were able to access this area with the support of staff in good weather. One relative told us, "In the summer they put tables in the garden and we can eat outside."

People had a photograph or other image that meant something to them on their bedroom door to enable them to identify their personal space. There was some signage in other areas of the service but improvement was required to ensure people were given maximum opportunity to find their way around independently. For example, signs for toilets were hanging from the ceiling and not always easy to see.

We recommend further adaptations to the environment are made in line with current best practice in dementia care.

We saw within people's care records that a pre admission assessment was completed before people moved to the service and initial assessment forms were completed by staff every day for the first seven days after admission. Information from these assessments was used when formulating people's care plans. Care plans made reference to the evidence based guidance used in their formulation. This meant staff had access to key information about how to support people in the right way.

Records showed most mandatory training was up to date. Mandatory training is training and updates the provider thinks is necessary to support people safely. This included first aid, safeguarding, challenging behaviour and end of life care. Some staff were overdue refresher training in dementia awareness (37%) and manual handling (27%). We were told that these sessions were being booked and following our visit we were sent confirmation of upcoming training dates and those staff scheduled to attend.

All staff had undertaken equality and diversity training. This had either been as part of a diploma in health and social care or as a stand alone course from an accredited trainer. Some staff had also completed an additional training unit entitled, equality, diversity and inclusion in dementia care practice.

New staff completed the Care Certificate as part of their induction. The Care Certificate is a training programme that was introduced within the care sector to ensure that workers had the opportunity to learn the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. They also shadowed more experienced colleagues before being included on the rota.

Records confirmed staff received regular supervision sessions and an annual appraisal to discuss their performance and development. The purpose of supervision was also to promote best practice and offer staff support.

People were supported to maintain their health and wellbeing. The service had close links with healthcare professionals such as the Intensive Community Liaison Service (ICLS) who offer assessment and interventions for people who display behaviours that challenge. People's care records contained evidence of visits and advice from a variety of professionals including community matrons, the falls team and the dietician.

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw DoLS applications had been made appropriately. DoLS applications contained details of people's individual needs and how decisions made about DoLS were in people's best interests.

Staff we spoke with had an understanding of MCA and why people had DoLS in place. Staff told us how they involved people in decision making where possible, for example when choosing what to eat or wear. One member of staff told us, "People have different levels of ability when it comes to making decisions. For example you can just open the wardrobe of [person's name] and they will choose what to wear. With other people it is much better to limit the choice to two outfits as they find this easier."

Good

Is the service caring?

Our findings

People's relatives told us they were more than happy with the care provided. Comments from relatives included, "The care here is first class. I have never seen anything other than good care and kindness shown", "Last year I recommended this home to a lady, she came and thanked me some time later for recommending such a caring home", "The staff are very affectionate towards the residents, it feels like a real home from home" and "[Family member] has a key worker, the staff know them inside out and the continuity of the staff and the care has helped maintain their health."

We observed positive relationships between people and staff. People were at ease in the company of staff and staff clearly knew the people they supported and their needs. Although at times some people became visibly agitated and vocal staff remained calm and professional and this created a calm atmosphere around the service. Staff spoke to people kindly and patiently and explained what they were doing before providing care. Interactions between staff and people who used the service were unhurried. We saw nurses crouching down to speak to people at eye level and allowing people the time they needed to take their medicines without rushing them.

Relatives told us they were always made to feel welcome when visiting their loved ones. One relative told us they visited every day, helped their family member with their food and was always given a meal themselves. Another relative told us their family member had recently been ill and staff had accommodated them in a bed close to their loved one so they could stay with them. A member of staff told us, "Family are highly involved with their family member's care."

Most of the relatives we spoke with felt the service kept them well informed. One relative told us, "The carers are kind and caring, they keep me up to date. The staff understand her needs and my need to understand her care." Another relative said, "I am kept fully up to date, I can ask how they are each day." One relative felt they had not been told in a timely manner when their family member had a health problem. We fed this back to the acting manager who told us they would look into this and update the instructions to staff regarding 24 hour contact with this relative.

Staff told us how they protected people's privacy and dignity. One nurse told us, "Staff are always very mindful of what we say and where we say it. If we need to have a discussion about someone we go into a quiet area with no one else around like the nurses office." People looked clean, nicely dressed and well cared for. The service provided an in house hairdressing service. One relative told us, "The hairdresser here looks after his hair and beard, he always looks smart." Another said, "I am very pleased with [family member's] care, her clothes are always clean and tidy. A third relative told us, "I have never seen [family member] dirty, they are very well cared for."

One member of staff told us, "This is a good team of staff, we are very caring and we work well together." Another staff member said, "I am very happy, I have been here ten years and I love it. I am proud of the care we deliver."

Information about advocacy support from external agencies was available. The manager told us about a local advocacy service they had referred people in the past but there was nobody using their service at present. An advocate is someone who represents and acts on a person's behalf, and helps them make decisions.

Good

Is the service responsive?

Our findings

Relatives felt involved in their family member's care and we saw evidence of this involvement in people's care records. One relative told us, "[Staff] keep in touch by phone if they need to discuss anything, we have recently had a meeting to include an advance care plan." Another relative told us, "I am included in care reviews and kept fully up to date."

Care plans were detailed and personalised. They contained clear information about the person and the best way to provide care and support to suit their individual needs. Records were well organised and reviewed regularly.

Due to the complex needs of the people using the service it was not always possible to involve them in the production or review of their care plan. However, we saw evidence that family members and health professionals were involved to ensure care was planned in the person's best interest.

Care records included an 'All About Me' document that contained information about a person's life history, likes and dislikes. There was evidence that family members were encouraged to contribute information for these documents and thereby give the staff a better understanding of the person's past and their preferences.

Throughout the day we observed staff providing care in a personalised way that reflected information we had read within care plans.

The provider employed an activities co-ordinator who worked at the service for two days each week. The activities co-ordinator was not working on the day of our inspection however there was an entertainer booked for the afternoon and we observed this activity which took place in one of the lounge areas. The person sang and played guitar whilst encouraging people to join in by singing along or playing percussion instruments such as tambourines and maracas. Staff also got involved with the activity and engaged with people in an upbeat and entertaining way. We saw one person initially sitting with a maraca and observing without very much interaction. With encouragement they began to smile and play the instrument and as the afternoon progressed they also got up and danced. The lounge was full of people and the majority of them were engaged and smiling during this activity.

Whilst the entertainer was evidently a positive addition to the day this did not take place until late afternoon and we did not see any activities taking place during the rest of the day. It is important to ensure that people are regularly offered activities to provide both entertainment and social stimulation.

We recommend that activities at the service are better organised to ensure more is offered to engage people on those days that the activities co-ordinator does not work.

The provider had a complaints procedure in place and relatives told us they knew how to make a complaint if necessary. One relative told us, "I am very happy, I don't have any problems. If I needed to I would speak to

the manager or the deputy."

There had been three complaints made in the 12 months prior to our inspection. These had all been logged appropriately and investigated in line with the provider's complaints procedure. Findings from the investigations and outcomes were all recorded by the acting manager.

At the time of our visit nobody was receiving end of life care. The provider had achieved Gold Standard Framework (GSF) accreditation. GSF is a systematic, evidence based approach to providing the best possible care for people approaching the end of life. We saw that some people had a 'do not attempt cardio-pulmonary resuscitation' (DNACPR) instruction and some people also had advance care plans in place. Advance care planning is the term used to describe the conversation between people, their families and carers and those looking after them about their future wishes for care. This meant staff knew what people needed and wanted when they came to the end of their lives. End of life care plans were not evident on every care file however and staff told us it was often difficult to engage relatives in discussions of this nature.

We asked how the service ensured the religious and cultural needs of people using the service were met. The deputy manager told us that they had contact information for local places of worship for a number of religious faiths and denominations. We were told staff had previously supported someone to have regular communion from a priest as this was something that had always been an important part of their life. At the time of our inspection there was nobody who had requested similar contact with a spiritual advisor. People's religious beliefs are also taken into consideration as part of the GSF process.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager 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.

The registered manager position had been vacant since the previous registered manager's contract ended on 18 August 2017. It is a condition of the provider's registration that a registered manager is employed at the service. At the time of our inspection no candidates had been interviewed for the permanent role.

The service had an acting manager in place until a new manager was recruited and they were being supported by an experienced deputy manager. The acting manager was also employed as a nurse at the service and their week was split between the two roles. They worked two or three nursing shifts each week and spoke to us about the challenges of balancing the two roles.

Relatives we spoke with knew the acting manager and the deputy manager well. A relative commented, "The manager is very approachable and always available to talk." Another relative told us, "The rapport between staff and management is excellent."

Staff said the acting manager was approachable and supportive. They felt that positive changes had been made by the acting manager and there was an open culture within the service. One staff member said, "It's a lovely team to work with. What you see with [Acting manager] is what you get." Another staff member said, "[Acting manager] is brilliant, I wish they would stay on as manager. [Deputy manager] is great too I really feel very well supported."

Staff meetings were being held, however, the acting manager acknowledged that these were not taking place as often as they would like. Meetings should have been held every two months. The most recent all staff meeting was held in September 2017 but prior to this there had not been a meeting since March 2017. Issues covered in meetings included staff ratios, security and updates on the management arrangements. Staff were also thanked for helping to decorate part of the service. Separate meetings were held for night staff to ensure they were also kept up to date and able to have their say. Minutes of staff meetings were taken so staff not on duty could read them later. Staff told us they felt able to voice their opinions and raise any concerns at these meetings but also felt able to approach senior staff or managers at any time between meetings.

Feedback was sought via an annual quality assurance survey. The most recent survey was conducted with relatives during February 2017. The response rate was 45% and the results were collated to produce an action plan. When we inspected on 1 November 2017 the action plan had not been completed. This indicates that feedback was being sought but action was not being taken promptly to address the issues raised. We were told that residents and relatives meetings should be held quarterly but the last one had

been in November 2016.

There was a quality assurance system in place to monitor key areas such as accidents, incidents and medicines administration. Six care plans were audited every month. This meant that every care plan was fully audited within a five month period. Regular maintenance and environmental audits were also carried out and the manager had oversight of these to ensure they were in order. A daily health and safety walk around was undertaken by the manager to ensure health and safety around the premises. These forms detailed any issues identified and action to be taken.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The acting manager had notified us of significant events in a timely way. This meant we could check that appropriate action had been taken. The service was correctly displaying the rating from the previous CQC inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective quality assurance systems in place to assess monitor and improve the quality and safety of the service. Regulation 17(2)(a)