Careline Lifestyles (UK) Ltd

Lanchester Court

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This was an unannounced inspection carried out on 29 & 30 October 2015.

We last inspected Lanchester Court in March 2015. At that inspection we found the service was meeting all the legal requirements in force at the time.

Lanchester Court provides accommodation for personal and nursing care for up to 22 people. Care and support is provided for people with learning, neurological and physical disabilities.

A registered manager was in place. 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.

Due to their health conditions and complex needs not all of the people were able to share their views about the service they received.

Summary of findings

People told us they felt safe but we had concerns that there were not enough staff on duty at all times to provide safe and individual care to people.

Risk assessments were carried out but they were not all accurate and up to date to identify current risks to the person. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. People received their medicines in a safe and timely way. However we have made a recommendation about the management of some medicines.

Staff received regular training, supervision and appraisal. However, not all staff had received specialist training that showed they were competent to carry out their role.

Systems were not in place to ensure people received a varied diet with special diets when the regular cook was not on duty.

Lanchester Court was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff did not all have a good understanding of the Mental Capacity Act (MCA) 2005 and Best Interest Decision Making and the Mental Health Act 1983 Code of Practice 2015 when people were unable to make decisions themselves.

Not all areas of the home were designed for the comfort of people who used the service.

People were supported to be part of the local community. They were provided with some opportunities to follow their interests and hobbies.

Staff said the manager was supportive and approachable. People were consulted and asked their views about aspects of service provision.

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 safe and individual care that met their needs.

Enforcement action is being taken as a result of our inspection findings outside of this 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?

Inadequate

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.

Records did not accurately reflect risks to people's safety.

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 have 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.

Is the service effective?

Requires improvement

The service was not always effective.

Staff were supported to carry out their role but they did not receive all the training they needed to do their job effectively.

Best interest decisions were not always made appropriately on behalf of people, when they were unable to give consent to their care and treatment. Staff had not all received training with regards to mental health and the requirements of the Mental Capacity Act 2005.

Systems were not in place to ensure people received a varied and specialised diet to meet their nutritional needs when the regular cook was not at work.

The building was not homely and did not provide a comfortable and separate sitting area for the benefit of people who used the service. It was showing signs of wear and tear in some areas.

Is the service caring?

Requires improvement

The service was not always caring.

Staff were kind and caring but there was an emphasis on task centred care rather than individual care and support of people.

People's respect and dignity was not always promoted, especially in relation to their personal care.

There was a system for people to use if they needed the support of an advocate.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always responsive.

People did not always receive support in the way they needed because staff did not have detailed written guidance about how to deliver people's care. People's care plans did not accurately reflect the current needs of people.

People were provided with some opportunities to access the local community.

People told us they knew how to complain if they needed to.

Is the service well-led?

Inadequate 

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 ethos of the service did not always promote and respect people's individuality. Care was provided to a diverse range of needs and routines were institutionalised at times.

The provider's quality assurance processes had not identified failings in areas identified in the report.

Lanchester Court

Detailed findings

Background to this inspection

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

This inspection took place on 29 and 30 October 2015 and was unannounced. The inspection team on day one consisted of two inspectors, an expert by experience and a specialist nursing advisor. On day two the expert by experience was not at the inspection. 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 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 obliged to send the Care Quality Commission (CQC) within required timescales. We carried out the inspection because of concerns from the commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams who also had concerns.

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 11 people who lived at Lanchester Court, three relatives, the registered manager, a compliance manager, a registered nurse, 12 support workers including two senior support workers, two members of catering staff and a domestic staff member. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some 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 ten people, the recruitment, training and induction records for five staff, nine 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 manager had completed.

Inadequate

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather their views. Other people said they felt safe and they could speak to staff. Comments included, "I feel safe living here," "I've been here for five years, it's been alright and I've always felt safe," and, "Staff are kind." Relative's comments included, "(Name) is really happy being here, we think they are safe."

We had concerns due to the range of people's diverse needs and the number of incidents that had been reported to the Care Quality Commission (CQC) that enough staff were not on duty at all times. The registered manager told us staffing levels were determined by Head Office. 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 20 people living at the home. The building contained 12 flats and 10 en-suite bedrooms to accommodate 22 people. We were told a nurse and ten support workers were on duty to provide care to 20 people from 8:00am to 8:00pm and four support workers and one nurse from 8:00pm to 8:00am. The nurse and senior support worker were not available to provide direct care at all times as they dealt with other duties such as medicines, clinical interventions, care plans, staff supervisions, liaising with professionals involved in the person's care and running the home in the registered manager's absence. We noted some people did not get their medicines in a timely way as staff were busy carrying out other duties.

Our observations and staffing rosters showed the staffing numbers were not always maintained each day to provide safe and timely care to people. At the time of inspection ten support workers were on duty and this included an agency member of staff who did not know the people in the home. The staff rosters also showed several days over the last three months when ten support workers had not been on duty. People's comments included, "Most of the time the staff levels are a bit low, I think they try but the problem is getting the staff. It's mainly on the nights-my supper is mostly late because of staff problems," and, "I often have to wait." Staff also commented, "There's supposed to be 10 staff on duty but sometimes we only have seven which can be hard to give people their one to one time," "When we are fully staffed it's fine but if someone is off we can be rushed," and, "Due to staff leaving and sickness we often work with only seven or eight care staff instead of 10." The registered manager told us head office had reduced the number of support workers from 11 to 10 in July 2015 as only 20 people were using the service, however this did not take into account people's needs.

We were told four staff provided one to one care for people and this included one support worker who provided one to one support for a person at all times. This left six people to provide support to 16 people. However when the required number of staff were not on duty people's care was compromised. A number of people required two members of staff for their moving and assisting and physical care needs. One person's care plan showed they required three staff for some of their personal care support. A number of people also had behaviour that was difficult to work with. Two care plans documented the extra staff that were required to provide support. Examples included, "Three staff may be required if Management of potential and actual aggression, (Mapa) training control is required," and, "At times of heightened anxiety two staff members to be present at all times in the immediate vicinity." Staff told us some people also required total assistance with all their care needs. Some people were confined to bed and required two hourly staff support in their rooms for their physical care. When staff were busy attending to people in their rooms other people had to wait for assistance or were at risk as they were not always supervised.

Staff were particularly busy because of the needs of the people and the layout of the building as people had the option to spend time in the communal area or be supported in their flat. We were told people may not always get their commissioned 'one to one time' as sufficient staff were not on duty. We heard the buzzers, when people called for assistance from their bedrooms or flats, went off on many occasions and calls were not always answered in a timely way. On one occasion we saw a staff member 'mute' the call bell on the panel in the communal area when we intervened to ask when staff would answer the call. This was instead of the call being attended to and the staff member turning off the call bell when they went to the person in their room. For another person confined to bed we saw they had no call bell available for them to use to alert staff. A relative commented, "(Name) has to wait as staff aren't always available when we ask, we've waited nearly an hour for some assistance" and, "It's brilliant here but short staffed, (Name), doesn't always get their 'one to

Is the service safe?

one' time." We observed several occasions when people had to wait for staff when they asked a question or asked for some assistance. Some staff answered, "In a minute", but then they became involved in another task and so the people waited or continued to ask other staff. One person waited one and a half hours to find out if they could go out Christmas shopping with staff support. This demonstrated enough staff were not available to provide safe, timely and individual care to people.

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

We had concerns that care and treatment including respite care was not planned and delivered in a way that ensured people were safe.

One person's care records had not been updated for three years, since their first admission. There was no evidence in this care record to show that any review of current needs or medication was undertaken. Staff did not adhere to specific instructions around maintaining use of equipment and what actions to take if problems arose. For other people risk assessments were in place but they were not all regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and to keep people safe. For example, choking risk assessments for three people showed they had not been evaluated monthly. For another person a 'positional turns' (regular change of position to prevent pressure area care) contract had been signed by the person which was to be reviewed monthly. It stated, "(Name) will not be woken at night for positional changes, staff will continue to encourage bed rest throughout the day." The record showed the contract had not been reviewed since it had been created in June 2015. Other risks specific to the person such as for falls, moving and assisting and personal care were in place but one person's falls risk assessment had not been updated since February 2015.

Although care plans were in place to show people's care and support requirements when they became distressed they were not regularly updated to ensure they provided accurate information. A person's behaviour management plan from February 2015 detailed action that should be taken if the person became distressed. For example, remove them from a noisy environment. Care plans did not contain detailed information to show staff what might trigger the distressed behaviour and what staff could do to support the person. We therefore had concerns care records did not provide detailed and up to date information for staff to provide consistent support to people and help them recognise triggers and help de-escalate situations if people became distressed and challenging. For example, an incident occurred when a person became "extremely agitated" with staff and techniques were used to try to diffuse the situation but the person remained agitated and distressed and they subsequently fell and fractured their hip. Records showed there had been a peak of 30 staff accidents logged between April and June 2015. The majority of incidents were where people had displayed challenging behaviour with staff. We were told the service had recruited a "high level" of new starters and they received management of potential and actual aggression (Mapa) training before they started working with people in order to protect people they worked with and themselves if an incident of aggression was likely to take place. A staff member said, "Staff can't start working with people until they've done Mapa training." However, some staff members told us they had not received this training before they began to work with people who used the service. We saw a procedure for 'physical restraint and use of reasonable force' by staff if an incident did occur that detailed the forms that needed completion after the incident. CQC had received several statutory notifications where the police had become involved. Some were due to people's distressed behaviour when staff had not been able to de-escalate the situation and either staff or people who used the service were therefore thought to be at risk. We had concerns agency staff that worked in place of regular staff did not all get the opportunity to read people's care plans to see how their care should be delivered before they provided direct care to people. We therefore had concerns robust systems were not in place for people to receive safe and consistent care.

This was a breach of Regulation 12 and 14 of The Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

We had concerns that people received improper care and treatment.

The registered manager was aware of potential safeguarding incidents that should be reported. A log book was in place to record minor safeguarding issues which could be dealt with by the provider. We found six concerns had been raised appropriately since the last inspection

concerning the care and welfare of people. This included two alerts raised by the police when two people in separate incidents had absconded from a secure building and become intoxicated in the community when they were deemed as being vulnerable. All alerts had been referred to the local authority safeguarding adult's team and had been investigated and resolved. A seventh safeguarding alert with regard to a serious incident had not been recorded but was still under investigation at the time of inspection by the relevant agencies external to the home. We had concerns the provider did not take the initial action to remove any implicated staff from work without prejudice, to protect people who used the service and the staff whilst a serious safeguarding incident was investigated.

Staff were aware of the reporting process for any accidents or incidents that occurred. We saw records called 'health and safety trends analyses' which were completed three monthly by the registered manager. Although the forms covered the numbers of accidents, safeguarding referrals, accidents to employees and notifiable incidents there was no evidence of analyses of these reports. We received conflicting information about areas of responsibility as we were told no action was taken as a result either by head office or by the registered manager to learn from incidents and to look at trends that may be evident. The compliance manager however told us the registered manager was responsible for carrying out their own analyses in the home for example from the accident log to make sure learning took place from incidents. We were told all serious incidents were audited by the responsible person at head office who investigated serious incidents separately.

Although staff had an understanding with regard to abuse we had concerns about the potential abuse of a person by their door being locked by staff to keep them safe. The person's care records referred to locking the person's door as part of their evening routine and afternoon routine when they had bed rest. The record stated, "(Name)'s door is to be locked and alarm must go on. Staff to regularly check on (Name.) We followed this up with staff who said they did not lock the door and we checked that the door was unlocked. The staff member who escorted us showed us how a key was used to turn a sensor on when the person was left alone in their room. This would trigger if someone other than staff went into the room. However, a current staff allocation record used by staff and written by a senior staff member referred to, "Making sure (name)'s door was unlocked." We considered reference to locking a person's door was confusing and misleading for staff and was abuse of a person if it were to take place even in the interests of keeping them safe from possible harm.

This was a breach of Regulation 13 of The Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Staff had a good understanding of safeguarding and knew how to report any concerns. They were able to describe various types of abuse and were able to 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 manager. One staff member commented, "I'd report any concerns straight to the manager, or the nurse in charge," "I've had local authority safeguarding training with Gateshead Council," "We do face to face training, not just training on the computer," and, "If I suspected anything, I'd report it."

We had concerns with some aspects of medicines management.

Medicines were given as prescribed. Staff members who administered medicines told us they would be given outside of the normal medicines round time if the medicine was required. For example, for pain relief. We saw there was written guidance for the use of some "when required" medicines, and when and how these should be administered to people who needed them, such as for pain relief. However, specific guidance was not in place for some people to advise staff 'when required' medicines should be used for agitation and distress to ensure a consistent approach. For example, one record stated, "Lorazepam as required for anxiety," and, another person's record described some diversional techniques that were to be used before considering the administration of the 'when required' medicine.

We saw most medicines were appropriately stored and secured within the medicine trolley and treatment room. We looked at a sample of four medicines and found they were all in date and stored appropriately. We saw bottled medicines had a date on to reflect when they were opened, however we saw loose medicines were not all dated to show when they were opened. Medicines which required cool storage were kept in a fridge within the locked treatment room. However, a vial of insulin in the fridge was out of date as its expiry date was 31 July 2015. Records

showed current temperatures relating to refrigeration were recorded daily. However the recommended minimum and maximum temperatures also required were not recorded daily. On 22 days in October 2015 it was noted the refrigeration temperatures exceeded the required temperature for the storage of refrigerated medicines. The registered manager said they would speak to the pharmacist to check if the quality of the medicines would have been compromised. The area manager told us a new fridge had been ordered for immediate delivery.

People received their medicines in a safe way. We observed medicines as they were administered to people. 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. One asked a person, "Are you ready for them now." They gave the person a drink with their tablets and then remained with the person to ensure they had swallowed them. 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.

Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

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

On both days of the inspection one domestic staff was available from 9:00am to 4:00pm. Rosters showed two domestic staff were available on approximately two days of the week to maintain the cleanliness of the building. However, we had concerns at least two domestic staff were not available each day to ensure there was a suitable standard of hygiene and cleanliness maintained at all times. Not all areas of the home were clean. We were told one bedroom or flat got cleaned every day. We observed some en-suite lavatories were soiled and we were told they were not cleaned every day. The handrails were sticky. Furniture and skirting boards were sticky and marked in some bedrooms. There was a malodour in two bedrooms. We saw staff allocation records that showed night staff had a substantial amount of cleaning of the building to do. We considered night staffing levels were insufficient to carry out the amount of main domestic tasks including hoovering and washing stairs as it reduced the amount of direct care and support provided to people who used the service.

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

A robust system was in place for dealing with people's money if they needed support. Two signatures were in place for all transactions, this included the person's signature and staff member, or two staff signatures if the person could not confirm the transaction. Receipts were in place for any money deposited in the home for safekeeping and for any purchases made. Financial records were reconciled each week by the administrator at the home and signed off by the registered manager.

We spoke with members of staff and looked at five personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. We saw the appropriate arrangements the registered manager had made when a nurse's pin number had expired whilst they were on maternity leave. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people. Copies of interview questions and notes showed the involvement of people who used the service in interviews and they showed how each staff member had been appointed. A person commented, "I sit on the interview panel when we're looking for new staff." The records all showed staff had been recruited correctly before they were offered their job and began working with people.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out such as for checking the fire

Inadequate

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alarm and water temperatures. A person commented, "I go round with staff every week to check and press the fire alarm, it gives people a fright." External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with promptly. 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.

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

Requires improvement

Is the service effective?

Our findings

CQC monitors the operation of Deprivation of Liberty (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These are safeguards put in place by the MCA 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 that as a result, 12 people living at the home were currently subject to such restrictions. We were told one person was appealing against the restriction.

We had concerns that records did not contain detailed information about people's mental health and the correct best interest decision making process, as required by the MCA 2005. Best interest decision making is required to make sure people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes.

Records showed assessments had been carried out, where necessary for people's mental capacity to make particular decisions. However, they were not reviewed on a regular basis. For one person we saw a written recommendation from the speech and language team that an assessment of the person's mental capacity should be undertaken on a regular basis to check their understanding of the risks and consequences of taking normal unthickened fluids. We did not find any evidence that these regular checks had taken place. We discussed this with the registered manager who was not aware of the detail in the letter requesting a regular assessment of the person's mental capacity and they told us this would be addressed.

Another person's records showed they were subject to a community treatment order but neither this nor the conditions were referred to in their assessment or care plans. Information was also not available that detailed any triggers that would indicate that the person was becoming unwell and action staff might need to take at the time. The need to have this information to hand, including reasons why the person might be recalled to hospital was discussed with the registered manager at the inspection.

Records showed that where people lacked mental capacity to be involved in their own decision making the correct process had not always been used. For example with regard to the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink). We saw 'best interest' 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. NICE guidelines state, "A best interest meeting involving 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." We saw four people received covert medication. No documentation was available for two people to show why this was required. For the other two people, the MAR record referred to the need and that it had been authorised by the GP. One person's care plan stated, "Carer at Lanchester Court has requested GP to put in writing that it's okay for (Name) to have medicines given to them in their food as otherwise they won't take it." There was no evidence to show if all other ways had been exhausted before the decision was reached. The registered manager said they would speak to the General Practitioner and arrange this.

Care records did not show where relatives had become Court of Protection approved deputies, or if they had enacted power of attorney for care and welfare if people lacked mental capacity to be responsible for their own finances and make decisions with regard to their care and welfare. The administrator and person from head office could tell us where people had appointees or deputies to deal with their finances. The registered manager could also tell us this information. However it was not recorded in people's records we looked at.

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

We had concerns accurate records were not in place to ensure people's nutritional needs were always met by staff and regularly reviewed. Systems were not in place to ensure people received a varied diet.

There were some systems in place to ensure people who were at risk of poor nutrition were supported to maintain their nutritional needs. 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. We were told people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST) and a nutritional screening tool. However, we found record keeping was variable and there was not a regular review of people's nutritional needs with up to date information for staff to respond to people's changing needs. For example, three records showed risk assessments had either not been completed or they had not been recently evaluated. Another person's records with regard to their use of a PEG feed had not been updated for three years to ensure they provided accurate up to date information for staff when supporting the person with their nutrition.

During the inspection the regular cook was on holiday and catering cover was provided by a support worker, who was not rostered to provide care on day one of the inspection and a chef from another service on day two. We found systems were not in place to ensure people received drinks and varied meals at regular times when the regular cook was not working. Written information was not available in the kitchen to inform any cook of the dietary preferences and specialised diets for people when the regular cook was not available. For example, diabetic, vegetarian and soft or pureed diets.

We found people did not receive an afternoon drink on day one. If we had not intervened people would have received the same food of fish and chips or pie and chips as was served the previous day. Instead people were then offered cottage pie or toad in the hole for lunch and jacket potato or tuna pasta bake for their evening meal. We were told four weekly menus were in place but these were not available for us or people using the service to view. We saw people usually had sandwiches for lunch and the main meal was in the evening. Rosters showed the cook worked from 10:00am until 4:00pm and therefore cooked breakfast was not served as the cook was not available to cook it. One person told us, "We use to get a cooked breakfast but not now." People had a choice of cereal for breakfast and we were told cereal was also provided for supper. We were told a Halloween party with a buffet was to be served at the weekend. One person said, "Buffets are rubbish," but another person said, "I like the buffet there's sandwiches, quiche and scotch eggs." Another person commented, "Food seems fine, I do get a choice."

We observed when people received a soft or pureed diet, portions were not separate but rather all the food was mixed together. We saw staff meeting minutes that reminded staff, "(Name) is not eating their food as the soft foods are mixed up and mashed together." The meeting minutes also reminded staff that people needed time to eat their food and to make sure they had a drink. We also saw written guidance in meeting minutes and the communication book relating to the position people needed to be assisted to eat in when they were confined to bed or needed support. However, this information was not all recorded in people's support plans.

This was a breach of Regulation 14 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Staff had some opportunities for training to understand people's care and support needs. Comments from staff included, "We get loads of training," Training takes place every other month," "Plenty of training," "Some of our training is face to face and we do e learning on line as well," and, "I've done lots of training including how to look after people who've had a tracheostomy (a tracheostomy is a surgical incision in the wind pipe to assist breathing) and continence care."

Staff told us when they began working at the service they had completed an induction programme and had an opportunity to shadow a more experienced member of staff for three days. This ensured they had the basic knowledge needed to begin work. They said initial training consisted of a mixture of face to face and practical training. Staff members comments included, "We do mandatory training before we start and then shadow a member of staff for three shifts."

We had concerns staff had not received the necessary specialist training to meet people's needs safely.

The staff training records showed staff received training in safe working practices. The manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. However, records showed staff had not received updated training with regard to Percutaneous Endoscopic Gastrostomy (PEG) training. (PEG is a tube which is placed directly into

the stomach and by which people receive nutrition, fluids and medicines.) This was needed to make sure staff knew how to deliver a person's care and treatment when they were fed by PEG.

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

Staff completed other training that gave them some knowledge and insight into people's needs and this included a range of courses such as, distressed behaviour, (Mapa), care planning and recording, equality, diversity and dignity, dementia care, Parkinson's disease, acquired brain injury awareness, continence care, tracheostomy, epilepsy, nutrition and hydration and professional boundaries. Staff had also received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty (DoLS) training.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals such as, General Practitioners (GPs), psychiatrists, district nursing teams, a dietician, a speech and language team (SALT) and tissue viability nurses. Records were kept of visits. Care plans mostly reflected the advice and guidance provided by external professionals. People's comments included, "I am happy with my healthcare," "I see a doctor every three months, and I get an appointment to see the doctor." A relative commented, "Healthcare here seems good to us, my (Name) has chiropody."

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 staff were aware of the current state of health and well-being of people. The staff told us a handover of verbal and written information took place between the nurses for each shift. A staff member told us, "Handovers are from nurse to nurse and senior carers inform the care staff." There was a detailed handover record that provided information for staff about people's health and well-being and other relevant information so they were aware of risks. Information included people's health, mood, behaviour, appetite and activities they had been involved with. Staff told us the communication book also provided them with information to help make sure people's needs were met. A staff member told us, "Communication is fine, we get information from the nurse at handover and we also all read the communication book and sign to show we've read it." We had some concerns however, that information given to staff during an admission for respite care had not been fully recorded or queried further by staff prior to the person having care provided to them. This lack of information had resulted in action not being taken to respond to the person's needs when they became unwell.

Staff said they could approach the management team at any time to discuss any issues. Staff members comments included, "The manager is approachable," "I feel very supported," and, "It's a supportive organisation, I can talk to my manager at any time." Records showed supervisions took place with staff. A supervision matrix was also in place to show they received regular supervision from the management team. A staff member told us, "I do some supervisions and I've had training about how to do them." The registered manager also told us supervision sessions were an opportunity to discuss staffs' performance and training needs. Staff said they received an annual appraisal to review their work performance. A staff member commented, "I've had training about carrying out appraisals but (Name) the manager does them."

The service was provided from a purpose-built building. The environment was not homely. There was no separate lounge. The communal lounge area where people congregated was an open thorough fare and offered people no privacy. Notices were placed on walls about the running of the service rather than ornaments or pictures being available for people to look at. There were only ten seats in this area so not everyone was able to have a seat when they wished to have the company of other people. We noted the temperature was hot, (82 degrees Fahrenheit) when several people were in the area, there were no windows so the doors were opened for air to reduce the temperature. We noted an out of hours visit by the compliance manager had found the doors in this area open at 3:00am as the building was hot and staff were busy elsewhere. This was a risk as someone could have left the building unobserved or an intruder could have come in without staff knowledge. We observed some areas of the building were showing signs of wear and tear. Paintwork to the doors and skirting boards in the hallways were marked and chipped due to wheelchair use. The flooring and walls in the communal kitchen were scuffed and marked. Some bedroom walls were also marked. A chest of drawers in one bedroom was broken. We saw the floor covering in the communal lounge area was discoloured and stained by the

Requires improvement

Is the service effective?

garden door. We saw some people's bedrooms and flats were individualised and decorated according to their preferences. They contained personal items to reflect their interests and personalities.

Requires improvement

Is the service caring?

Our findings

People who used the service and relatives we spoke with were positive about the care and support provided. People's comments included, "All the staff are kind and caring," "The staff treat me with respect, I am happy with them," "The staff are okay but I don't want to be here, I want my own place," "The staff are great," and, "There is nothing wrong here but I have decided I want to live on my own and I will do that one day." Relative's comments included, "We think the staff are kind, they are like friends to us," and, "The staff are brilliant."

Staff interacted well with people and spent time with them when they had the opportunity. We saw people were supported by staff who were warm, kind and caring. We heard a staff member referred to as "auntie," and this was not discouraged by the staff member as not being age appropriate. We observed one staff member take time to prepare "roll up" cigarettes for a person when they asked for them. People's care plans did not always provide detailed information for staff of how people communicated. For example, if they were in pain. One care plan stated, "Staff to observe (Name) when doing personal care as they can't communicate that they have pain." However, there was no information to clarify how they would communicate that pain and what the staff response should be. This meant information was not available so staff who did not know the person well would not be able to recognise signs and respond appropriately to help reduce the person's pain.

We had concerns peoples dignity was not always respected.

People's dignity was not always respected. We were told dedicated night staff were not employed but rather there was a rolling programme of staff working days and nights. We were told male carers were involved in attending to females during the night and we did not see information in people's care plans with regard to people's wishes about choice of male or female carer. We also did not see any written protocol advising that male staff should not carry out personal care with females. If two staff were required for moving and assistance, people's care plans did not stipulate a female would carry out the personal care to protect the person's dignity.

This was a breach of Regulation 10 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

From our observations we considered improvements were needed to ensure care was not institutionalised. The communal area was chaotic and noisy at times and it was cramped because of the seating arrangements, it did not provide any privacy for people. Some care plans stated people became upset and agitated in a noisy environment and the people should be removed from it but we saw this did not happen. One care plan stated, "Noise to be kept to a minimum so if noise levels rise the person should be encouraged to go somewhere quieter such as the activities room." We observed people were served breakfast and lunch from a trolley in this area on some days. On one day we observed hoovering, washing of the floor and other domestic tasks took place whilst people were sitting or sleeping in wheelchairs in the area. People, including those with limited mobility, had to move and stand and wait as their seats were pulled out and furniture moved to the centre of the room. People also had to avoid trip hazards such as an electric wire and wet floor sign as they waited to be seated again.

We saw staff did not always have time to interact with people except when they carried out care and support. A television played quietly each day in the background and showed some programmes that people were not interested in as we saw they didn't watch them. We observed people who were more assertive interacted together or tried to get staff involvement. As staff were busy they didn't always have time to respond to a person's request so the person kept asking different staff members. We saw staff did not take the opportunity to engage and interact with some people and encourage their awareness and interest in their surroundings. Two people sat in their wheelchairs all the time when they were out of bed. On the first day of inspection one of the people sat in their wheelchair all day, they slept for most of the day apart from when their relatives visited. We observed some people also remained in their bedrooms/flats without stimulation and staff did not spend time with them except when they took meals and carried out tasks with them.

Not all of the people were able to fully express their views verbally. Support plans provided detailed information to inform staff how a person communicated. For example, "(Name) has no problems in understanding information

Requires improvement

Is the service caring?

given to them. (Name) uses a letter board to communicate, staff must place a pencil in between (Name)'s fingers on their left hand and allow them to point to each letter." Another support plan stated, "(Name) is able to communicate effectively however at times of agitation and when they are frustrated they may not want to communicate with staff." Staff supported people to be independent and to maintain some control in their day to day living. For example, one person had a possum, which is an electronic aid strapped to their leg which enabled them to alert staff if they required assistance and to alter the speed on their electric wheelchair.

There was information displayed in the home about advocacy services and how to contact them. Advocates can represent the views for people who are not able to express their wishes. The registered manager told us two people had the involvement of an independent advocate. Two workers from an advocacy service called "Your Voice Counts" also visited the home at the time of inspection. We were told this was their first visit and the registered manager had arranged for them to have meetings with people who lived at the home. This was a forum for people to speak independently rather than just to staff at the home.

Requires improvement

Is the service responsive?

Our findings

We were told people's needs were assessed by a pre-admission co-ordinator at head office before people moved into the home. This was to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort.

We had concerns that records did not accurately reflect people's care and support needs for staff to provide the correct care and support to people in the way the person wanted and needed. We also had concerns care plans were not accessible to all staff to read as they were kept in the manager's office which was kept locked when it was not in use. We had concerns people did not always receive consistent care and support over the day and night with the same staff members attending to the person so they knew the person's preferred routine.

Records contained assessments that were transferred to support plans but we saw they were not all up to date and did not reflect people's current needs. These included for, communication, mobility, personal care, nutrition and other needs. We saw they were generalised and did not detail the interventions needed for staff to support the person in the way they wanted and needed. People's support plans were not all updated monthly to reflect any change in people's care and support needs. We were told they were updated three monthly if people had non nursing needs and monthly if people had nursing needs. We saw the evaluation only recorded "no change" and did not provide detail of people's health and well-being over the period. Some records were out of date and did not reflect people's current care and support needs. For example, a person's personal hygiene care plan from October 2014 stated, "Staff to encourage (Name) in completing their daily tasks, oral hygiene needs and assist as needed." From our observations this did not reflect the person's current level of increased need. A mobility care plan from October 2014 for the same person, confined to a wheel chair, also did not accurately reflect their needs, it stated, "(Name) can have days when they can want to walk themselves and gets agitated when staff try and help." We checked with staff who told us this was no longer the case as the person could not weight bear any longer. This could have resulted in inappropriate care and support being offered to the person that could have placed them at risk.

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

Written information was available that showed people of importance in a person's life. Staff told us people were supported to keep in touch and spend time with family members and friends. Most people had visitors every week. Some people went to spend time at home on 'home leave'. A person told us, "Sometimes I go to my partner's place across the road." A relative commented, "I visit every week and staff are very welcoming and helpful."

Records showed that reviews or meetings took place for people and their relatives to discuss their care and to ensure their care and support needs were still being met. Relatives we spoke with said they were involved in review meetings to discuss their relative's care needs. They said they were kept informed if there was any change in the health needs of their relative. Their comments included, "We are told of any changes in (name)'s care," and, "We do get involved in meetings."

People told us 'My Say' meetings took place every month to discuss some issues regarding the running of the home. Meeting minutes were available which showed items discussed included, meals and menus, outings and activities, safety and respect. One person told us, "Yes, we have meetings but nothing gets done." A support staff member responded and said, "The menus get changed every time you ask." We saw meeting minutes did not tell people about action that had been taken since the previous meeting as a result of people's comments. People were therefore not clear that their feedback had been acted upon.

Records showed people were supported to become part of the local community. Some people attended college supported by staff. Others went to a disco every week. People, told us they went out for meals with staff and some had been to 'Wet and Wild', the gymnasium and swimming. We observed people who had 'one to one' time had more opportunities to go out to places and to pursue their previous interests and hobbies such as shopping, for meals out and to concerts. We were told the home shared a minibus with another home and it was available for trips out. One person told us, "We've been to Saltwell Park, South Shields and the coast." Another person said, "I haven't been out since July when I went out with my social worker."

Requires improvement

Is the service responsive?

We saw a programme of activities that was available, although no organised activities took place during the inspection. We observed staff encouraging people to become involved in making decorations for a Halloween party.

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 seven had been received and they had been investigated and resolved. One person told us, "Yes, I've been given written information about how to complain," One relative said, "We haven't had a complaints leaflet but we would know how to complain if we needed to."

Inadequate

Is the service well-led?

Our findings

A registered manager was in place who had become registered with Care Quality Commission in 2013. The registered manager understood their role and responsibilities to ensure notifiable incidents such as safeguarding and serious injuries were reported to the appropriate authorities.

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

Records showed audits were carried out regularly. However they failed to show action that had been taken as a result of previous audits where deficits were identified. 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 to ensure people received safe care in the way they wanted and needed.

We saw records of spot checks that were carried out by the compliance manager at regular intervals at nights and at weekends to check aspects of care provision. However, we did not see that any identified actions had been followed up as a result of visits or audits.

We found that the systems in place for managing and mitigating risk were inadequate. The actions taken to review care records had not led to the recognition that these did not contain the information staff needed to safely care for people or to highlighting that they were out of date. Neither, did the systems highlight the training gaps and the lack of understanding staff had around the Mental Health Act 1983 (2015) and the Mental Capacity Act 2005. The registered manager openly acknowledged that they lacked the skills for this role and needed to develop their management competencies.

Staff said they felt well supported by the registered manager. However, we had concerns due to the high turnover of staff, that systems were not in place to ensure a stable staff team was employed. As regular staff were not available, care to people was not delivered in a safe and consistent way that promoted continuity of care to people. We also had concerns that the approach to care which was in place was institutional and did not promote person centred care for all people. For example, staff involved in the delivery of people's care did not have access or get time to read people's care plans to show how people's care needed to be delivered in a safe way and the way they wanted.

At the time of inspection we found the service to be busy and chaotic and staff did not all know what other staff were doing. We saw an allocation sheet was available each day in the communal area that recorded allocated tasks for staff to carry out at certain times of day but not how the care and support was to be provided. Staff did not have access to care records which were kept in the registered manager's office to inform them how the care was to be delivered to each person. People's current state of well-being was communicated verbally and in daily notes. A communication book contained instructions to remind staff how a person's care should be delivered. For example, with regard to nutrition and if it wasn't delivered in a certain way staff were informed they would be disciplined. This meant that care was task centred and although it was to try and ensure people's care needs were met it was not safe or flexible.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us regular meetings took place and these included general staff and nurses 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 health and safety, new admissions, safeguarding process, staff performance, the environment and people's care.

The registered manager told us 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 who used the service. Surveys had been completed by people who used the service in 2015. We saw the findings had been analysed but the results did not reflect how many surveys had been sent out or completed and returned and the action taken as a result of the findings was not evident or recorded.

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	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured staffing levels were sufficient and staff were trained to provide safe and person centred care to people at all times. **Regulation 18 (1) (2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not ensured care and treatment was provided in a safe way for all people. They had not assessed current risks to people's health and safety and tried to mitigate all risks, ensuring that persons providing care or treatment to people had the qualifications, competence, skills and experience to provide people's care. **Regulation 12(1)(2)(a)(b)(c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not ensured care and treatment for service users was not provided in a way that significantly disregarded the needs of the service user for care and treatment. **Regulation 13 (1)(4)(d)**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The 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. **Regulation 15 (1)(c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The registered person had not ensured people's nutrition and hydration needs were regularly reviewed during the course of their care and treatment and any changes in people's needs responded to in good time. **Regulation 14 (1) (4) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person had not ensured people were treated with dignity and respect at all times. **Regulation 10(1)(2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had not acted in accordance with the requirements of the Mental Capacity Act 2005 and associated Code of Practice. **Regulation 11(1)**

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 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 mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk, by maintaining an accurate, complete and contemporaneous record for each person; evaluating and improving their practice. **Regulation 17 (2)(a)(b)(c)(f)**