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The Beeches Nursing and Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of The Beeches Nursing and Residential Care Home on 13 and 22 August 2018. The first day of the inspection was unannounced. We informed the manager of our second day of inspection .

At our last comprehensive inspection of The Beeches Nursing and Residential Care Home on 8, 15 and 22 November 2017 we found evidence that people who used the service were at risk of significant harm. We found breaches in five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The inspection in November 2017 identified that people did not receive safe care and treatment. Staffing levels and the deployment of staff did not ensure people's care needs were met. Recruitment procedures were not robust. Risks to people were not appropriately assessed and managed. We found serious concerns with the management of medicines. The premises and equipment were not clean and properly maintained. Infection control was poor and people had not been protected from environmental risks. Emergency evacuation plans were not available for all people. The certificate to confirm that there had been professional testing of the electrical systems, circuits and any other service carrying electricity around the building was not available. The building was not suitably heated and environmental risks were not managed. We rated the service as inadequate.

We carried out a focussed inspection of the service on 20 March 2018 to determine if any improvements had been made. The inspection highlighted some improvement. However, Inspectors did identify breaches in Regulation 11: Need for Consent and Regulation 12: Safe Care we identified two breaches in regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found further work was needed to ensure mental capacity assessments were decision specific and we found that best interest decisions were not recorded in care plans. Improvements were needed in bathrooms and in the cleanliness of the service. We rated the service as Requires Improvement.

Following the inspection, we asked the provider to complete an action plan to show what they would do and by when to improve all five key questions to at least Good.

At this inspection of the service on 13 and 22 August 2018 we found the service had deteriorated and rated the service as Inadequate. We found the provider had failed to follow their action plan. We identified significant shortfalls in the quality of the care people were receiving and we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to our concerns we served a Notice of Decision to restrict admissions to the service without prior agreement of the Care Quality Commission.

The Beeches Nursing and Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The

service provides nursing and personal care for up to 31 people some of whom are living with a dementia. Care is provided over two floors. At the time of the inspection there were 20 people who used the service.

At the time of the inspection the registered manager was absent from the home. However, the deputy manager had stepped up and was acting as manager. 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.

During our inspections in November 2017 and March 2018 we found that the home was in breach in relation to safe care and treatment. At this inspection we looked to see if the required improvements had been made. We found this breach in regulation had not been met.

We found serious concerns with the management of medicines. The recording of medicines was not accurate and specific guidance to support staff with the administration of medicines was not always available. We found gaps in the recording of the temperatures of the medicine fridge. In addition, fridge and treatment room temperatures were too high. This meant the quality of medicines may have been compromised.

Risks for people who used the service were not always adequately assessed to ensure people were safe and where possible, actions identified for staff to take to mitigate the risks occurring.

We found areas of the service to be unclean and infection control was poor. We found stained carpets, stained and dirty bed linen, unclean bathrooms and dirty toilet brushes. The laundry room needed refurbishment. In addition, staff frequently left the laundry door open which meant people could access the laundry and come to harm. Some people were living with a dementia and would not understand the possible consequences if they were to go into the laundry.

Fridges and freezers were dirty both on the seals and internally. We found that raw meat was not stored correctly in the fridge. It's important to store meat safely to stop bacteria from spreading and to avoid food poisoning. We reported our concerns to environmental health.

The passenger lift had not had a thorough examination as required under the Lifting Operations and Lifting Equipment Regulations (LOLER). This is a legal obligation to ensure a competent person, independent of the company responsible for servicing or preventative maintenance, carry out a LOLER inspection twice yearly. During the inspection the passenger lift was taken out of action until the appropriate safety tests had been undertaken. We reported our concerns to the Health and Safety Executive.

The arrangements for Fire safety were inadequate. A representative from County Durham and Darlington Fire and Rescue Authority visited the service on 28 August 2018 and found non-compliance with fire regulations. We have been informed by the representative of the fire authority that they will continue to monitor progress to the areas of concern.

At times there were insufficient staff to meet the needs of people who used the service and this had resulted in people's care being compromised.

Checks were made before new staff started work to make sure they were of good character and safe to work with people. However, we did find that profiles were not available for all agency staff who worked at the service. This meant the provider could not be sure agency staff were suitably qualified and had the clinical

skills to support people and to confirm they were of good character.

Staff had received supervision on an irregular basis and not in line with the providers policy which was a minimum of five supervision sessions a year. Training and annual appraisals of staff were not up to date.

The standards within the induction programme provided at the service were not aligned with the standards in the Care Certificate. The care certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in social care. There were no records to confirm agency staff had received an induction in relation to people who used the service, expectations and safe working practices.

During our inspections in November 2017 and March 2018 we found that the home was in breach in relation to consent because the Mental Capacity Act (2005) guidelines were not always followed. At this inspection we looked to see if the required improvements had been made. We found this breach in regulation had not been met.

During the inspection we walked around the service and found many bedrooms and communal areas in need of redecoration and refurbishment, particularly on the ground floor. The carpet in the main lounge and downstairs corridor was stained. The service was not dementia friendly, signage was poor and there was no cohesion in the design, theme or colour scheme. Repairs to the service were needed internally and externally.

There was insufficient monitoring and oversight of people's nutrition and hydration. In addition, staff failed to make a timely referral to an occupational therapist for one person who used the service for an assessment for a suitable chair. As this person was assessed as being unsafe to sit in an ordinary chair they were being cared for in bed until the assessment had been carried out.

People told us they were happy with the quality and variety of meals offered.

People were not always treated with dignity and respect. Staff failed to ensure people's needs were met and this compromised their dignity. After lunchtime we found some people to have clothes stained with food, but staff did not support people to change their clothes. Some people who used the service had dirty finger nails.

Care records were insufficiently detailed to ensure the care and treatment needs of people were met. Care plans were brief and task based, with less specific information to guide staff.

Activities and outings were limited and particularly for those people living with a dementia.

Quality monitoring of the service was ineffective as it had not identified the concerns that we had found at the inspection. The provider had not obtained adequate feedback from people to monitor and improve the quality of care and service provided.

Staff were aware of the different types of abuse and were confident senior staff would take the appropriate action in respect of this.

People and relatives told us that staff were caring, kind and considerate.

People and their relatives told us they would raise any concerns they had with staff or the manager and were

confident these concerns would be dealt with.

Staff during discussion. demonstrated a passion about the service and their support of the manager. They spoke of good team work and how they were committed to improving the standards and quality of care at the service.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

For adult social care services, the maximum time for being in special measures will usually be no more than12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The system for the management of medicines was not safe and effective.

Risks for people who used the service were not always adequately assessed to ensure people were safe and where possible, actions identified for staff to take to mitigate these occurring.

The service was unclean and infection control was poor. People were placed at risk of harm due to poor maintenance of risks within the environment of the home.

The systems in place for the control and management of legionella were inadequate. The passenger lift had not been inspected to make sure it was safe for use. There was non-compliance with fire regulations.

There were insufficient staff to meet the needs of people who used the service.

Is the service effective?

Inadequate

The service was not effective.

There was insufficient monitoring and oversight of people's nutrition and hydration.

Staff had not received supervision on a regular basis. Annual appraisals of staff were not up to date.

The standards within the induction programme were not aligned with the standards in the Care Certificate. Staff training was not up to date. There was no evidence to confirm that agency staff had received an induction.
The manager and staff were not working within the principles of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

The service needed redecoration and refurbishment. The environment was not dementia friendly. There was no cohesion

in the design, theme or colour scheme. Signage around the service was poor.

Staff failed to make a timely referral to health care professionals

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

Staff spoke to people in a kind and caring way. People told us they were treated with kindness and their independence was encouraged.

Is the service responsive?

Inadequate

The service was not responsive.

Care records were insufficiently detailed to ensure the care and treatment needs of people who used the service were met.

Activities for people were limited and in particular for those people who were confined to bed and/or living with a dementia.

People and relatives told us they could approach staff should they need to complain.

Is the service well-led?

Inadequate

The service was not well-led.

Quality monitoring of the service was poor and had not identified the concerns we had found at the inspection.

There was no overall analysis of the accident audit.

The provider had failed to seek adequate feedback from people to monitor and improve the quality of care and service provided.

The manager had regular meetings with staff and people who used the service. Staff and people confirmed they were encouraged to share their views.

The Beeches Nursing and Residential Care Home

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 checked whether the provider was 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.

We inspected The Beeches Nursing and Residential Care Home on 13 and 22 August 2018. The first day of the inspection was unannounced, which meant that the staff and provider did not know we would be visiting. We informed the manager of our second day of inspection. The inspection team consisted of two adult social care inspectors, a specialist advisor who was a nurse and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information about the service. The provider had sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We sat in communal areas and observed how staff interacted with people. During the inspection we spoke with 10 people who used the service and seven relatives. We looked at communal areas of the home and some bedrooms.

We spoke with the manager, the provider, the newly appointed deputy manager (appointed after our inspection on 13 August 2018), the operations manager who was also a registered manager of another service operated by the provider, activity co-ordinator, kitchen assistant, handyman, office administrator, a senior care assistant, a nurse and generally to other care staff. During the inspection we spoke with a visiting

health professional. We also contacted contracts and commissioning teams and other visiting professionals to seek their views on the service provided.

During the inspection we reviewed a range of records. We looked at two people's care records in detail and specific areas of other people's care plans. We looked at the medicine records of five people. We also looked at staff files, including staff recruitment and training records, records relating to the management of the service and a variety of policies and procedures developed and implemented by the provider.

Inadequate

Is the service safe?

Our findings

During our inspections in November 2017 and March 2018 we found that the home was in breach in relation to safe care and treatment. At this inspection we looked to see if the required improvements had been made. We found this breach in regulation had not been met.

During the inspection we found serious concerns with the management of medicines. The recording of medicines was not accurate and specific guidance to support staff with the administration of medicines was not always available. For example, one person was prescribed a medicine on as needed basis (PRN) to relieve constipation, however the dose on the Medicine Administration Record (MAR) differed from the dose entered on the PRN protocol. PRN protocols assist staff by providing clear guidance on when medicines should be administered and how often. Without clear directions this person was at risk of harm of receiving too much or too little medicine to relieve their constipation.

Another person was prescribed a medicine to decrease the amount of acid in their stomach and this should be administered 30 minutes before food. However, there were no specific instructions on the MAR in relation to this.

Another person who used the service was prescribed medicines for a medical condition. This medicine needed be given at specific times to ensure the person did not lose the ability to manage their symptoms. This medicine was prescribed to be administered at 1pm, however on the first day of the inspection this person did not get their medicines until 2pm. In addition.

One person was prescribed medicines to be administered as a patch. The service had a system in place for recording the site of the application and the days when the patches were renewed or replaced. This was necessary because the application site needs to be rotated to prevent skin damage. However, we saw gaps in recording when patches had been applied and removed.

One person received support with medicinal creams. However, the body map was not completed to show where the creams should be applied. In addition, we saw that the MAR was not specific and stated that the cream was to be applied "as needed". There was insufficient guidance to support staff with the administration of medicines which placed people at risk of harm.

Medicines which required cool storage were stored appropriately in a fridge which was within a locked room. Temperatures were recorded twice daily, however, minimum and maximum temperatures were not recorded. There were some gaps in recording of fridge temperatures and on four occasions the temperature was above eight degrees centigrade. This is higher than recommended for cool storage (between two and eight degrees Celsius) and action had not been taken by staff to ensure medicines were safe to use.

Temperatures for the treatment room where medicines were stored, were recorded daily. On six occasions in August 2018 temperatures were recorded as above 25 degrees Celsius. This is higher than the recommended temperature of between 15 and 25 degrees Celsius.

Fridge and treatment room temperatures need to be recorded to make sure medicines were stored within the recommended temperature ranges. This meant that the quality of medicines may have been compromised, as they may not have been stored under required conditions.

Risks for people who used the service were not always adequately assessed to ensure people were safe and where possible, actions identified for staff to take to mitigate these occurring. For example, the risk assessment documents for one person who used the service stated that this person had no awareness of potential risks and was unable to summon help in an emergency. However, a decision was made to move this person to another room without involvement of other health professionals. This room was in an area that was not staffed overnight. Staff told us they checked on this person every hour during the night. Should there be an emergency situation at times when staff were not present then this person was at risk of harm. This was pointed out to the manager who had discussions with other health professionals and the person was moved back to an area of the service in which they could summon the help of staff.

Staff told us one person was transferred in a shower chair with a chair strap from their bedroom to the shower, when they were to go in the shower. There wasn't an assessment undertaken to ascertain that this was a safe method of transfer for this person who had poor posture. This placed the person at risk of harm. After the inspection we raised a safeguarding alert to the local authority in respect of this person.

We found there to be issues with the environment, cleanliness and infection control. We found stained carpets, stained and dirty bed linen, unclean bathrooms, dirty toilet brushes and a commode which was stained with faeces. Domestic bins in bathrooms and some bedrooms did not have disposable bin liners and a clinical waste bin in the first-floor shower room was broken and did not open with the foot. In this shower room there wasn't any liquid soap for staff and people to wash their hands and there were cobwebs and dead flies within the shower room. We found malodour in some areas of the service. A relative told us, "The place is a bit smelly."

In the first-floor communal bathroom we found a wire exposed from a skirting board, which was not rectified until after our inspection. The toilet seat was stained and fixed with one, rather than two brackets and thus moved and there was no bin for paper towels. In addition, there was no thermometer to take the water temperature of the shower before it was used. In two toilets on the ground floor there was no toilet roll holder and walls were stained underneath the soap dispenser.

A bathroom on the ground floor was used for storage. The door of this bathroom was locked with a standard bolt which would be easily opened by people who used the service. The toilet floor near to the COSHH cupboard was extremely slippery. The bedroom next to the nurses' office was also being used as a store room, but this room was not locked and could be accessed by people.

The laundry room on the ground floor of the service was dirty, walls were stained and in need of repainting and the floors were sticky and slippery. Some of the walls were damaged and the washers were sat on a large piece of stone which was not washable. In addition, staff frequently left the laundry doors open which meant people could access the laundry and come to harm. Some people were living with a dementia and would not understand the possible consequences if they were to go into the laundry. Within the laundry there was contaminated clothes, bedding and towels, in addition to equipment, hot water and cleaning products. Leaving the door to the laundry open placed people at risk of harm. The conservatory floor was both sticky and slippery and people had access to the conservatory which placed them at risk of trips/falls.

We looked in the kitchen and found fridges and freezers were dirty both on the seals and internally. The chest freezer was full of ice and had not been defrosted in some time. We found that raw meat was not

stored correctly in the fridge. Raw meat was stored on a shelf above some dairy products. This meant juices from the raw meat could drip onto other foods and cause cross contamination. We found a rotten cucumber in with other cucumbers and the liquid from the rotten cucumbers had contaminated the others.

The provider had failed to protect people from the risks associated with inappropriate or unsafe care and treatment because the service was unclean and infection control was poor. In addition, people were placed at risk of harm due to poor maintenance of risks within the environment of the home. We reported our concerns to environmental health.

During this inspection we looked at the systems in place for the control and management of legionella and found that these were inadequate. The risk assessment was insufficiently detailed and had been undertaken and reviewed by staff who were not competent and trained to do so. To prevent legionella, taps in sinks, baths, outside areas and showers should be run weekly and toilets should be flushed. We looked at records during this inspection which confirmed that taps in unused/rarely unused areas and showers had not been run weekly. There were no records to confirm toilets had been flushed.

We asked to see the servicing/inspection of the passenger lift including Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). LOLER requires that all equipment for lifting is fit for purpose and subject to thorough examination. We were provided with a preventative maintenance record but there was no evidence of LOLER. There is a legal obligation for providers to ensure a competent person, independent of the company is responsible for servicing or preventative maintenance, carry out a LOLER inspection twice yearly. During the inspection the passenger lift was taken out of action until the appropriate safety tests had been undertaken. Taking the lift out of action did not impact on people as there were no people accommodated on the first floor of the service.

Throughout the year the service had experienced problems with the heating and hot water. This meant at times there had been no hot water or heating.

At the Commission's request a representative from County Durham and Darlington Fire and Rescue Authority visited the service on 28 August 2018 and found non-compliance with fire regulations. The fire risk assessment was not robust and they raised concerns about the evacuation of people who used the service in the event of an emergency. Many fire doors needed attention as they did not close or had other issues. Tests of the fire alarm had not been undertaken on a weekly basis. Some emergency evacuation plans for people who used the service had not been updated to reflect some changes or information was missing. Staff had not taken part in a fire drill or simulation of practice and fire training was out of date. We have been informed by the representative of the fire authority that they will continue to monitor progress to the areas of concern.

All the above constitutes a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At times there were insufficient staff to meet the needs of people who used the service. The service had been without a laundry assistant for at least six weeks and care staff were expected to cover the laundry, however staffing levels had not been increased to cover this. There has been a high turnover of staff and sickness which had meant staff covering different roles within the service. Each day kitchen staff finished their shift at 5pm and after this time care staff were responsible for serving food to people, tidying the kitchen and stacking the dishwasher. These tasks took staff away from their caring duties. During our discussions with staff they all confirmed there were insufficient staff on duty to meet people's needs and this had resulted in their care being compromised. The service was not fully staffed and had a high reliance on agency staff.

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

We asked people who used the service if they felt safe. One person told us, "Yes they [staff] will do anything to help you." Another person told us, "Staff do their best. I'm alright."

We looked at staff recruitment and selection to ensure relevant security and identification checks were carried out before any new staff started work. We saw that checks had been undertaken with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring checks on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and adults. In one of the staff files we looked at we found there was only one reference. The operations manager told us two references were available when they last did an audit at the service. However, we did find that profiles were not available of all agency staff who worked at the service. This meant the provider could not be sure agency staff were suitably qualified and had the clinical skills to support people and to confirm they were of good character.

Staff we spoke with during the inspection were aware of the different types of abuse. They told us they had received safeguarding training and were confident to raise any concerns to the manager.

We looked at records to confirm that checks of the building and equipment were carried out to ensure health and safety. We saw that checks had been made on fire alarm, nurse call fire extinguishers.

Inadequate

Is the service effective?

Our findings

During the inspection we looked at the providers supervision policy which stated there was an expectation that staff would have a minimum of five supervision sessions each year. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. We looked at the supervision matrix but we were unable to determine how many supervisions staff had received in a year as the matrix just detailed when supervision was due. We looked at individual staff records and found that staff had received supervision on an irregular basis and not in line with the providers policy. In addition, annual appraisals of staff were not up to date.

Although formal supervision sessions had not taken place with staff, they told us the manager was very approachable and provided guidance and support in their work.

The induction policy stated that all staff would undertake an induction programme that was developed in line with the Commissions and Skills for Care guidance. We looked at the induction records of four staff and found that staff had not enrolled or completed the Care Certificate Induction as expected by the Commission. The standards within the induction programme were not aligned with the standards in the Care Certificate. The care certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in social care.

The service had a high reliance on the use of agency nurses to cover some shifts, However, no evidence was available to confirm that agency staff had received an induction particularly in relation to people who used the service, expectations and safe working practices.

We looked at the training matrix and found that not all staff were up to date with their training. Only 44% of staff had completed training in end of life, 50% of staff had undertaken training in equality and diversity, 59% of staff had achieved training in challenging behaviour, 63% of staff received training in fire safety and no staff have undertaken training in diabetes. This meant not all staff had received training that provided them with the knowledge and skills required for their job role. The provider told us the high turnover of staff had impacted on the ability to keep staff training up to date.

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

During our inspections in November 2017 and March 2018 we found that the home was in breach in relation to consent because the Mental Capacity Act (2005) guidelines were not always followed. At this inspection we looked to see if the required improvements had been made. We found this breach in regulation had not been met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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

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. The manager did not have a clear understanding of their legal responsibilities. Mental capacity assessments had not been completed for people or best interest decisions made for their care and treatment. For example, a person who used the service received their medicines covertly (disguising medicines by administering it in food or fluids). There was a letter from the GP authorising the administration method, which stated that covert medicines were to be given in the person's best interest, however we did not see a decision specific Mental Capacity Assessment and a best interest meeting between the GP, pharmacist and care home staff.

We looked at the care records of one person who had advanced dementia and did not have the mental capacity to understand or make decisions about their care and treatment. From examination of records we found that a relative had signed forms for consent to treatment, taking photographs and social media on their behalf, however there was no documentation to confirm the relative was a legally authorised representative. No best interest meetings had taken place with the people, staff and other professionals involved in their care.

We asked to see evidence of those people lacking capacity and who were subject to a DoLS authorisation with any conditions attached. We were shown a matrix with the names of those people subject to an authorisation, when this had been applied for and the date of expiry. In addition, we were also given a folder which contained DoLS authorisation records from the local authority. However, the information on the matrix and that in the DoLS file was contradictory. For some people there was no evidence of an authorisation from the local authority.

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

During the inspection we walked around the service and found many bedrooms and communal areas in need of redecoration and refurbishment, particularly on the ground floor. The carpet in the main lounge and downstairs corridor was stained. The windowsill in the conservatory was cracked and broken. The brackets where there had been a heater were still fixed to the wall which posed as a risk of injury to people. In bedrooms there were no bright colours or matching curtains and bed linen. The signage on the walls, some pictorial to prompt people to the toilet for example, was produced on a computer on paper and placed in a poly pocket. Some of the signage was worn, making it difficult for people to see. Some signage was in place on the outside of bedroom doors, with a name and photograph, however this was not on all doors. Other than some toilet seats that were red in colour to aid people living with a dementia the environment was not dementia friendly. There was no cohesion in the design, theme or colour scheme.

Externally we noted some of the walls of the service needed repair and one of the external walls was stained which was suggestive of a leak. On the patio area near to the conservatory there were cigarette ends on the paving stones and a large amount of cigarette ends in a bucket. This was not a pleasant environment for people to sit out.

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

2014.

There was insufficient monitoring and oversight of people's nutrition and hydration. One person who used the service needed support with managing their hydration and nutrition to minimize the risk of malnutrition and/or dehydration. This person had been seen by the dietician who recommended the person have regular snacks in between meals. We looked at food charts and found no evidence to support that snacks had been given in between meals. The same person was to be weighed on a weekly basis, however we found there was inconsistent recording on different forms and gaps in the recording of weights. The lack of monitoring placed this person and risk of harm through malnutrition and associated risks.

The hydration plan for another person stated they must drink at least 1600 mls of fluid a day to reduce the risk of dehydration and reduce the risk of urinary tract infections. However, the fluid intake was not sufficiently monitored. There were gaps in the recording on fluid balance making it difficult to determine the actual amount of fluid the person had taken. When fluid intake was less than the minimum intake required staff had not taken any action to prompt the person to increase their fluid intake. In addition, staff did not have sufficient oversight of this person's weight. We raised a safeguarding alert to the local authority in respect of concerns for this person.

The safe care plan for one person stated that a referral to the occupational therapist was to be made in December 2017 as they wanted a professional assessment with a view to providing advice on a suitable chair for the person to sit in. Staff told us this person had behaviour that challenged and would only sit in the chairs in the home for about five minutes before they became restless. They told us this person was at risk of falling from the chair when they became restless. Staff at the service failed to make this timely referral. Staff told us this person was not safe to sit in the chair and they now spent most of their time in bed. We have raised a safeguarding alert to the local authority in respect of this.

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

People told us they were supported to have a good diet and enjoyed the food provided. One person commented, "The food is homemade and you get plenty of it. We get tea, juices and snacks. Another person told us, "You have a choice of food, I like salads, they [staff] always ask what I want. They know I don't like carrots." We spent some time observing the lunchtime period and found it was organised and relaxed. Staff interacted with people in an unhurried was and provided them with a choice of food and drink.

"They do their best" was a common response when we spoke with people who used the service and relatives. One person told us, "They do their best. They are caring lasses [staff], they have limited resources, they can only do so much." A relative told us, "They [staff] do their best but they are always so busy."

People had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including, GPs, speech and language therapists and the advanced nurse practitioner who visited regularly to see people who used the service. One person commented, "They [staff] will go with me to appointments at the hospital. The optician comes here and the hairdresser too." One relative told us, "[Person] has always been looked after well. The communication is good. They would ring the GP if [person] was poorly."

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity and respect. After lunchtime we found some people to have clothes stained with food but staff did not support people to change their clothes. One person had chosen soup for their lunch and we noted that this soup remained around their mouth after lunch. We noted some people to have dirty finger nails and another person wearing somebody else's trousers.

During the inspection we walked around the service and heard a person who was behind a closed door calling for help. We alerted staff who then went into the person's bedroom. This person said staff had not been to support them and this had resulted in them being incontinent. Staff attended to this person immediately. Staff told us that this person did not use their nurse call for assistance, they shouted when they needed help. This person's bedroom was at the far end of the corridor. As such they may not be heard. We raised a safeguarding alert to the local authority in respect of this.

On the first day of the inspection we heard another person who used the service calling for help. Their bedroom door was open. They were sat in a chair which was situated out of reach of their call bell. This person told us they needed to go to the toilet. We had to find staff to support this person. Staff failed to ensure this person's needs were met by ensuring they had a call bell to summon the help of staff and this compromised their dignity. We raised a safeguarding alert to the local authority in respect of this.

On leaving the service on the second day of the inspection, we heard the same person calling for help. They told us they wanted to go to the toilet. We noted a staff member in the corridor speaking with some relatives who was in close enough distance to hear this person, however they did not respond to the calls for help. We had to go into the dining room to summon the help of staff. Again, this compromised the person's dignity and respect.

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

People who used the service told us they liked staff and described them as caring. Comments included, "Last year, on my birthday, they surprised me and made a cake. I got cards. I was over the moon" "If you are upset they talk to you with a cup of tea. They help you out" "I drink a lot of lemonade and it's [the glass] always filled up. I've never been in a home like it. They [staff] are lovely."

A relative told us, "They [staff] are all very pleasant. They chat and joke. They always care." Another relative commented, "They [staff] do their best and yes they are caring."

Observations throughout the inspection showed staff were polite, friendly and caring in their approach to people. However, we did note one staff member in the dining room who was loud and standing up and feeding two people at the same time. We spoke to the manager and informed them of this.

People were relaxed, happy and could freely move around all areas of the service. There was good rapport

between people and staff. Staff engaged in an unhurried way chatting about common interests and what was important to the person. Staff knew people's names and listened to people in a kind and caring manner.

People who used the service told us they were supported to maintain links with family and friends. Staff could tell us about people's relatives and how they were involved in their care. Relatives told us they were made to feel welcome when they visited.

The staff spoke with fondness about the people they supported. They understood the importance of promoting equality and diversity, respecting people's religious beliefs, their personal preferences and choices. People were involved in making decisions about how they wanted their care and support provided. People said staff supported them to make their own decisions about their daily lives.

People were supported to be as independent as they were able to be. We saw staff encouraged and supported people to mobilise. Staff provided words of reassurance and were patient as they encouraged people to mobilise independently.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. At the time of our inspection no one in the home had an advocate. Advocacy information was made available to people who used the service.

Inadequate

Is the service responsive?

Our findings

As detailed in the safe section of this report care records were insufficiently detailed to ensure the care and treatment needs of people who used the service were met. Care plans we looked at contained limited person-centred information on people's support needs. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. Care plans were brief and task based, with less specific information to guide staff.

One person who used the service had a specialist airflow mattress on their bed as they were at risk of pressure ulceration. However, there was no written guidance as to the level the air flow mattress was to be set at, the care plan stated, 'set at level required for current weight and check minimum once daily', there was no associated documentation confirming this. We pointed this out to the registered manager to take action to address this.

During the inspection we spoke with staff about activities for people who used the service. We were told there was no budget for activities and as such activities and outings were limited. However, staff did some fund raising to purchase items for activities and entertainment. Activities taking place included arts and crafts, bingo, snakes and ladders and a fortnightly exercise class.

Some people who used the service were living with dementia and spent most of the day in their bedroom. We found activities for those people living with a dementia or confined to bed were insufficient. Each person had an activity record. However, the activities listed on each record were the same for each person who used the service. For example, on 4 June 2018 the activity for all was snakes and ladders and on 5 June 2018 the activity was a quiz. This indicated there was no choice and some of the activities listed were not suitable for all people who used the service.

We looked at the activity records for one person who was living with a dementia. Many of the activities listed such as jewellery making and card making were inappropriate as they were unable to take part because of their dementia. The only interaction and stimulation on this person's activity record was on some days a 'little chat'.

We looked at the care records of another person living with a dementia. The care records stated that this person liked to have their nails painted. We looked at this person's nails when we visited on 13 and 22 August 2018 but their nails were not painted. In addition, we looked at the activity records for this person from 4 June 2018 until 7 July 2018, however there was no evidence to support they had their nails painted. This meant this person was provided with limited stimulation.

All the above constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We asked people about the activities at the service. One person told us, "I like puzzle books and watching the birds out of my window. I like the television." Another person said, "The school children came here and

we made blankets. I've been to the shops. I get all of the news off the television."

In between our inspection days, four people who used the service enjoyed a day out at Seaham sea front to see Tommy and to have fish and chips. Tommy is a statue of a First World War soldier. The manager told us they were planning to arrange more trips out.

The manager understood their responsibility to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The manager said they could access information regarding the service in different formats to meet people's diverse needs. Staff knew people well and knew how each person communicated.

People and relatives told us they felt comfortable speaking to the manager or staff if they had any concerns. One person said, "I see [manager] often. They do their best whatever I ask." A relative said, "I would ring whoever, but I've no complaints."

At the time of the inspection, no people using the service were receiving end of life care. The service understood the importance of providing good end of life care to people and supported people to have conversations about their wishes for the end of their life.

Inadequate

Is the service well-led?

Our findings

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help providers assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The manager and operations manager showed us many audits and checks which had been carried out. These audits looked at health and safety and infection control. In addition, a daily walk round of the service was undertaken by management to look at general cleanliness and health and safety.

We found the quality monitoring of the service delivered was poor. We asked to see the daily walk round sheet for the 13 August 2018 to see if this had identified the areas of concern that we had identified, however this could not be found. The monthly audits undertaken by management were ineffective as they failed to pick up on the areas of concern that we identified at this inspection.

We looked at the accident audit for May, June and July 2018.The accident analysis recorded the time that each person had fallen but there had been no overall analysis of fall times for all people to establish if there were any trends or patterns to the falls. From examination of records we found there were more falls between the hours of 4pm and 12pm. The manager was aware that most falls had occurred during this time, however, no action had been taken to try and prevent/reduce this.

The operations manager who was also the registered manager of another of the providers care homes told us they had been providing day to day support in the running of the service since January 2018. They told us they had been undertaking monthly audits. We were provided with audits carried out in in January, March and May 2018. Audits for February, April, June and July 2018 could not be found. These audits were ineffective as they did not pick up on any of the areas of concern that we identified at the inspection of the service.

We asked to see the most recent survey sent to people who used the service. We were provided with four completed surveys. The manager was unaware why only four surveys had been completed. In addition, the same survey had not been sent out to people. Two of the surveys we reviewed asked questions about the food and two were general satisfaction surveys. This meant the provider had failed to seek adequate feedback from people to monitor and improve the quality of care and service provided.

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

Staff were keen to speak with us during the inspection and showed their passion for the service and their support for the manager (who had stepped up from the deputy manager role). One person told us, "This is the happiest, I've ever felt. We need a chance to get the home up and running. [Manager] has everyone to give her a hand. [Manager] is working the floor. [Name of new deputy manager] started as deputy on Monday. I feel like I can go to [manager] and say what I think we need. [They] listen and are approachable. No matter where you go, [manager] is around and will always help you. We wouldn't be without [them]."

Another staff member told us, "We work really hard. The management is much better. Everyone is working together. We've got [operations manager] coming in to help us. [Manager] is working non-stop. The staff we've got now all work together as a team. There's no bickering. Everyone is working the best they can."

People who used the service spoke highly of the manager. One person told us, "If [manager] can put it right [they] will do it straight away. [They] have a laugh with you and you can have a joke." Another person said, "[Manager] is very nice. They [staff] all are."

People and relatives told us there were meetings with the manager in which they were encouraged to speak up and share any concerns or ideas. Staff told us they had attended staff meetings and they were given the opportunity to share their views. Management used these meetings to keep staff updated with changes affecting the service.

The manager understood their role and responsibilities, and could describe the notifications they were required to make to the Commission and these had been received where needed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Systems were not in place to ensure the safe management and administration of people's medicines. Risks for people who used the service were not always adequately assessed to ensure people were safe and where possible, actions identified for staff to take to mitigate these occurring.

The enforcement action we took:

We placed a condition on the providers registration. The Registered Provider must not admit any new service users without the prior written agreement of the Care Quality Commission.