Wellburn Care Homes Limited

Ryton Towers

Inspection report

Whitewell Lane
Ryton
Tyne and Wear
NE40 3PG

Tel: 01914138518
Website: www.wellburncare.co.uk

Date of inspection visit:
17 February 2016
18 February 2016
19 February 2016

Date of publication:
18 April 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 17, 18 and 19 February 2016. The first day was announced.

We last inspected this service in May 2014. At that inspection we found the service was all the legal requirements in place at the time.

Ryton Towers is a care home for older people, some of whom have a dementia-related condition. It does not provide nursing care. It has 43 beds and 32 people were living there at the time of this inspection.

The service did not have a registered 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.

People and their relatives told us they felt safe and well protected in the home. Staff had been trained in the safeguarding of vulnerable people, but this training had not always been put into practice in recognising potential abuse.

There was an experienced, skilled and trained staff team, but staffing levels were variable and did not always meet the minimum levels needed to meet the assessed needs of people in the home. Staff recruitment processes were not fully robust and required more stringent checks to be carried out.

Risks to people were assessed and appropriate measures were taken to ensure their safety. People's medicines were safely administered. Building safety was regularly checked and routine maintenance and servicing of equipment and services took place.

Staff knew people's needs and preferences well and treated them as individuals. Staff were given regular training to enable them to recognise and meet people's needs, and were encouraged to undertake personal professional development. Staff were supported in their roles by regular supervision and an annual appraisal of their performance.

People were not asked to give their consent to their care, and their rights under the Mental Capacity Act were not fully respected. Where people lacked capacity, decisions made in their best interest were not always made in consultation with the appropriate people, and lacked sufficient detail.

People's healthcare needs were assessed and met appropriately. Routine health checks were arranged and the service worked with other professionals and services to ensure specialist needs were met. People were supported with their nutritional needs and enjoyed a good diet.

People and their relatives spoke highly of the very caring nature of the staff team. They told us they were

treated with care, consideration and affection by all the staff, They said staff responded to people's changing needs.

People and their relatives told us they were kept aware of any developments in the service and were given the information they needed to make decisions about their care. Relatives were informed of any changes to a person's health or wellbeing, and were invited to reviews of care. Advocacy was made available where required.

Staff took care to protect people's privacy and dignity at all times and to enhance their wellbeing. People were encouraged and supported to be as independent as possible. Regular activities and trips out were arranged.

The format used to assess people's needs did not adequately address their social, cultural or spiritual needs. Care plans were sensitive and person-centred, but did not always set clear goals or have sufficiently detailed guidance to staff about how they should meet people's needs.

People told us they were listened to by the management and staff and had few complaints. Where complaints were received, they were not properly documented and the outcomes were not clear.

The service did not have a registered manager in post. The acting manager had ensured that there was good continuity of care whilst a new manager was being recruited. There was a positive atmosphere in the service and the views of people, their relatives and staff were sought and considered. Systems were in place to monitor the quality of the service, but these had not been fully effective in identifying some areas of improvement.

We have made a recommendation about giving people more choice at mealtimes.

We found breaches of Regulations regarding Staffing; Need for Consent; Safeguarding; Person-centred care; and Complaints. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Staffing levels did not always meet the minimum required to meet the assessed needs of people.

Staff had been trained to recognise potential abuse, but had not always applied that training.

Risks to people were assessed and steps taken to protect people from harm.People's medicines were administered safely.

Is the service effective?

Requires Improvement

The service was not always effective. People's rights under the Mental Capacity Act were not fully respected, because decisions made in their best interests were unclear and did not always involve proper consultation.

Staff were supported in their roles by regular training, supervision and appraisal.

People's health needs, including their nutritional needs, were assessed and met.

Is the service caring?

Good

The service was caring. People, their relatives and professionals told us the staff were very kind and caring at all times.

People and relatives were given good information about the service and their care, and told us they were involved in all aspects of the service. Advocacy was arranged where required.

People's privacy and dignity were respected, their wellbeing was enhanced, and they were encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's needs were not fully assessed.

Complaints were not always recorded and responded to professionally.

People were encouraged to make choices in their daily lives and were offered a range of social activities, including regular trips out

Is the service well-led?

Requires Improvement

The service was not always well-led. There was no registered manager in post.

Systems to monitor the quality of the service provided were not fully effective.

There was a culture of openness and inclusiveness. People were asked their views about their service.

Ryton Towers

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 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.

This inspection took place on 17, 18 and 19 February 2016. The inspection was unannounced and was carried out by one adult social care inspector.

Before the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales.

We contacted other agencies such as local authorities to gain their experiences of the service. We received no information of concern from these agencies.

During the inspection we talked with 12 people and three relatives. We spoke with nine staff, including the acting manager, two senior care assistants and the area manager. We 'pathway tracked' the care of three people by looking at their care records, talking with them and with staff about their care. We reviewed a sample of four staff personnel files; and other records relating to the management of the service, including medicines, recruitment, staff training, supervision and appraisal, accidents and quality monitoring systems.

Requires Improvement

Is the service safe?

Our findings

People told us they felt the staff protected them from any harm. One person said, "I feel safe here." A second person said, "I feel safer here than I did at home. I have no concerns here." They also told us the staff were hard working and attentive, but often stretched. One person told us, "There's not enough staff. They always come, but not quickly. They tell me I have to be patient." Another person said, "We are short staffed, we need a manager." A third person told us, "You wait half an hour for meals. You spend your life waiting."

Relatives told us they felt the home provided a safe environment. One relative told us, "I knew it would be a safe place. The quality of care is excellent. I've seen nothing of concern." Another relative said, "We don't worry when we leave. We know our (relative) is safe here."

We asked the acting manager how the required staff hours were calculated. They told us they used a dependency assessment tool weekly to determine people's needs and the hours required to meet those needs. We compared the assessed needs for the month of January 2016 with the actual staff hours worked. We saw there was not a consistent match between these. On two weeks in the month the service had been staffed in excess of the hours required. However, in the other two weeks of the month, staff hours had been significantly below (56.5 hours and 51.5 hours) the required levels. The acting manager told us this was due to staff sickness and staff shortages. We were told the service had no bank of 'as and when required' staff and relied on staff accepting extra shifts, which they could not always do. We judged the staffing levels were based on the availability of staff, rather than the assessed needs of people living in the service.

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

The service had a policy for the safeguarding of vulnerable adults, and a 'whistle blowing' (reporting bad practice) policy which was prominently displayed for staff's attention. A log was kept of all safeguarding incidents. We saw there had been five such incidents recorded in the previous twelve months. These incidents had not been recorded in sufficient detail for us to be assured the provider had acted appropriately in response to the allegations raised.

Staff told us they were aware of the safeguarding policy and had received regular training in how to recognise and respond to any suspicions of abuse. They were able to describe the signs they would look out for that might indicate abuse, for example, a person becoming withdrawn, tearful or fearful. Staff were clear that any suspicions of abuse would be passed immediately to the acting manager. However, in the course of the inspection we found verbal and documentary evidence that indicated potentially abusive practice with regard to one person in the home. We discussed this with the acting manager, who told us they had not recognised the practice as being potentially abusive and said they had been following professional guidance. We also discussed this issue with the area manager, who had been unaware of the practice and who immediately stopped the practice and reported the incident to the local authority safeguarding adults' team.

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

People were protected from financial abuse. Any monies held for, or spent on behalf of, people living in the service were stored securely and appropriately accounted for. Receipts were kept and all transactions had two signatures. The accounts were subject to monthly internal and external audits. A separate 'social fund' for the general benefit of people in the home was maintained to the same standard.

We noted the provider did not have a policy for the implementation of Human Rights legislation and did not require staff to attend Human Rights training. The area manager undertook to address this issue and subsequently informed us that dates had been arranged for this training.

The service carried out assessments of risks to people who lived in the home, staff and visitors. The policy required the assessor to balance the risks to the person against the importance of maintaining people's independence and ability to make decisions about their lives. General risks assessed included manual handling, administration of medicines, skin integrity and the use of bed rails and consuming alcohol. Risks specific to an individual, such as driving, smoking and consuming alcohol, were also assessed. Where risks were identified, measures were incorporated into the person's care plan to mitigate those risks by, for example, providing sensor mats for people at risk of falling during the night. Where it was felt a person needed additional aids or specialist equipment for their safety, staff liaised with the person's social worker or made a referral to an occupational therapist. All accidents to anyone in the service were recorded and analysed, to see if there were steps that could be taken to prevent a repeat of the incident.

The acting manager was aware of the new Duty of Candour conferred by recent changes to legislation. They told us the area manager had given the registered managers in their group a presentation regarding this duty.

Appropriate systems were in place for ensuring the safety of the building. A senior care assistant acted as health and safety officer and fire warden. This person undertook regular checks of fire safety systems and equipment; water temperature and quality; and general environmental risks. An annual fire safety risk assessment was carried out, and there were regular fire drills. We saw evidence of the regular maintenance and servicing of equipment and services. An asbestos management plan was in place. The acting manager told us the provider responded promptly when any repairs were needed. The acting manager told us they had completed a four day certified health and safety course run by the Institute of Occupational Safety and Health.

Business continuity plans were in place to respond to any emergencies or other issues that might impact on the provision of safe care. Areas covered included relocating people from the building; severe weather; gas leak or other service failure and water damage to the building. We were told the plan was reviewed every six months.

We looked at how the service recruited new staff. We saw that some areas of the recruitment documentation lacked clarity. For example, although applicants were required to give an employment history, the layout and directions of this section were unclear and did not result in sufficient detail being obtained. In addition, although there was a requirement that applicants gave two employment referees for the provider to contact, the form did not ask for the designation of those referees. Nor did the application form require the applicant to give a clear 'yes/no' answer to the question, 'Do you have any criminal convictions?' These loopholes meant the recruitment system was not fully robust. The area manager told us the provider was already aware of these deficiencies, and was in the process of revising the recruitment documentation

accordingly.

The provider had a policy in place for the safe management of people's medicines. If a person was able to take responsibility for their own medicines, this was encouraged, subject to a risk assessment. One person self-medicated at the time of this inspection. Appropriate systems were in place for the ordering, checking and storing of medicines. Medicine administration records (MARs) were clear, up to date and had no unexplained gaps. Staff told us they followed up any omissions to check if the person's medicine had been given, and reported the issue to the acting manager. Each person's MAR had their photograph attached, to prevent them being given the wrong medicines. People's preferences for how their medicines should be given were also recorded on the MAR and in the person's medicines care plan, as were any allergies.

Staff with responsibilities for administering people's medicines told us they received regular training in the safe handling of medicines and had their competency regularly assessed. Records confirmed this. Medicines at risk of misuse, known as Controlled Drugs, were stored securely and recorded in a separate book, with two staff signatures required for each administration. We observed part of a medicines round. The senior staff member administering people's medicines explained to people what their medicines were and asked for their consent before administering them.

Requires Improvement

Is the service effective?

Our findings

Most people told us they felt staff provided their care effectively. One person told us, "Staff are well trained. They know what they are doing."

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the service had applied to the relevant authority for authorisation to restrict the liberty of 11 people in the home.

We looked at how the service obtained people's consent to their care. The only specific document we found in people's care records was one asking for consent to being photographed. The acting manager told us staff used to ask people to sign their care plans to show their consent, but the care plan format had since changed, and no longer included a section for this. We saw only one care plan which had been signed (by a person's relative).

The acting manager told us that, if there were any concerns about a person's capacity to make significant decisions, a formal mental capacity assessment was carried out. If the person was judged to lack capacity for a particular decision, a meeting was held with the person's family or representatives, and any involved professionals. We were told this meeting took the relevant decisions, in the best interests of the person. However, records showed the majority of such decisions had been made solely by the previous registered manager, and did not include the views of the person, their family or other representatives. In addition, we found most best interest decisions lacked sufficient detail, were insufficiently specific about what decisions were being made (for example, 'care and treatment'), and did not give clear guidance to staff. In one instance, we found a best interest decision had been made which concluded there was a need for a behavioural management plan to be drawn up regarding an area of personal care for one person. No such management plan was on the person's care record, and staff interventions had inadvertently led to distress to the person.

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

Staff we spoke with had good knowledge of the needs of the people they cared for; knew their likes, dislikes and personal histories; and could describe people's preferences for how their care should be given. A visiting professional commented, "The staff have the knowledge and skills they need. I know that from the conversations I've had with them and the questions they ask. I've never been aware of any training

deficiencies."

We saw evidence that new staff members received a thorough induction, in line with the standards laid down by the national training organisation 'Skills for Care'. This included initial training in health and safety, infection control, food hygiene, manual handling, first aid, fire safety, safeguarding and person-centred care planning. The acting manager told us new staff shadowed experienced staff until they were judged to be competent to work unsupervised. We saw that arrangements were in place for the introduction of the Care Certificate, and one staff member had commenced this training. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.

We looked at the staff training matrix to see what training staff were given. We found that the large majority of staff were up to date with all the training required by legislation and received annual refresher training. This included training in food hygiene, health and safety, infection control, medication awareness, equality and diversity, safeguarding and nutrition. The only topic of training that had not been routinely given to staff was that of working with people whose behaviour could be described as challenging. We were given evidence that this training had been booked for the months of March and April 2016. We noted that ancillary staff were given the same training as care staff.

The acting manager told us staff were encouraged to request further training, over and above the training given to all staff, to aid their personal professional development. Examples of this included nine staff who held National Vocational Qualifications (NVQ) level three in social care; the deputy manager held NVQ level 4. Other staff had requested advanced training in health and safety and administration of medicines.

Records showed all staff members received formal supervision every two months. The acting manager told us the computer system was used to flag up when a staff member's supervision was due. We discussed the format used to structure supervision meetings with the area manager, who told us this was in the process of being revised, to increase the focus on identifying areas for personal development and allow for the clearer setting of goals. An annual appraisal of each staff member's performance was undertaken. This process was also under review, we were told, with the aim of increasing the emphasis on staff self-assessment.

Where people had made advanced decisions about their future care, this was documented clearly. Examples seen included care plans that set out people's advanced care wishes, and Do Not Attempt Resuscitation (DNAR) forms. Where another person held legal powers such as Lasting Power of Attorney, this was also recorded. People's care record files were colour coded to indicate to staff that a DNAR or Deprivation of Liberty Safeguard was in place for the person.

People's nutritional needs were assessed on admission to the home, using the Malnutrition Universal Screening Tool. This is a screening tool to identify adults who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop a care plan. Appropriate referrals were documented to dieticians and the speech and language team. People's weights were recorded monthly, or more frequently, if there were concerns. We spoke with the chef, who was knowledgeable about people's individual food needs and preferences, special diets and the general nutritional needs of older people. Menus were varied and nutritious.

People told us they enjoyed their meals. Comments included, "Very good food"; and, "The food is getting better". Some people felt the portion size was too large, with comments including, "There's too much", and, "The dinners are too large." We noted meals were served ready plated, so people did not have the option of deciding how much they ate. One person told us, when discussing the menu before the meal was served, they "didn't care for parsley sauce" and were "not fond of broccoli". We saw they were served with both.

Another person told us, "I keep telling them I don't like sauce on my ice cream", but they were served this. It was replaced when the person complained. We discussed these issues with the acting manager who said they would review how people's preferences were communicated to the kitchen and how they could be given better choice when being served their meals.

We saw jugs of water and juice were available to people in their rooms and lounges, and with meals. One person told us, "We get plenty to drink." Staff told us people could have snacks and drinks when they wanted, including during the night.

People's healthcare needs were assessed and met appropriately. Each person had a general health care plan in place, and routine appointments were made with dentists, opticians and for hearing tests. Details of visits from, or appointments with, health professionals were recorded on the care record, along with any advice or treatment proposed. Where appropriate, requests had been made to people's GPs for referrals to more specialist services such speech and language therapists. People told us they were happy with the attention paid to their health. One person said, "I've had new glasses, new teeth and a hearing aid since I came here."

We recommend that the service seek advice and guidance from a reputable source, about improving the meal time experience for people, with particular focus on giving choice.

Good

Is the service caring?

Our findings

People told us the staff were caring and considerate. One person told us, ""We are treated very well, it's very good, here. All the staff are very friendly and try to help, and they are kind and caring." A second person said, "The carers are very good. They treat me with respect." Another person commented, "I get cuddles and kisses from the staff, and they tell me they love me. The staff are very, very good – I call them 'Angels'"

Relatives we spoke with were equally positive about the quality of the care given to their family members in the home. One relative told us, "The care is tremendous, day and night. The carers are interested and smiling in their approach, and our (relative) thoroughly enjoys the pampering they get from the staff. Our (relative) is a different person from when they came in. It's made a difference to the whole family." A second relative commented, "The staff are experienced, mature, very caring and they go the extra mile. This is as near to perfect care as you can get." Other comments from relatives included, "The staff go out of their way. Nothing is too much trouble for them"; and, "We are made to feel part of the family when we visit."

There was a good rapport between people and staff, and an evident mutual affection. Staff members approached people in a respectful and courteous manner, spoke clearly and gave people time to respond. They demonstrated patience, good humour and gentleness. Where they were assisting people, they explained what they were about to do, and gave any necessary reassurance. We saw entries in the service's 'compliments file' that supported these observations. Comments seen included, "It has been amazing to see your attitude towards those in your care"; and, "Your help, support and caring are second to none."

An equality and diversity policy was in place, and staff had received the relevant training in this area. The aim of the policy was stated as being, 'To develop self-awareness by staff and people to ensure discrimination does not occur, and is challenged if it does occur.' The acting manager told us there were no people from religious, ethnic or cultural minorities, currently using the service. People were encouraged to practice any faith they had. A Church of England service was held every three weeks, and there were weekly visits by a Catholic priest. People's right to engage in the political process was respected and postal votes were arranged for those who wished before local and national elections.

We asked the acting manager how they involved people and their families and provided information. We were told staff worked through a 'new resident induction' checklist to orientate people to their new environment. This included informing them of the staff call system, fire safety systems and the complaints procedure, and introducing them to other people and staff. They were also given a service user guide, with other relevant information about the home and the services available to them.

The acting manager told us meetings were held every two months with people and their relatives to get feedback, act on any problems and encourage good communication. Typical agenda items included meals, activities, trips and care issues. As well as these face to face opportunities, people were made aware of the request book and suggestions box, which were checked regularly by the acting manager. A relative told us, "We get loads of information. They keep us involved in what is going on."

Other information was displayed in public areas of the home. This included an 'Information and Advice' document, giving advice to people and families about what to look for in a good care home; information on Alzheimer's and memory loss; NHS mental health services; and a link to the Care Quality Commission website to read inspection reports. The provider's quarterly magazine, the Wellburn Post, was available, with news, people's views and stories.

We found many good examples of staff's attention to people's wellbeing. They encouraged people to keep in touch with family and friends, providing a portable pay phone, and the offer of Skyping. Personal pampering included aromatherapy and weekly hand massages. People told us staff encouraged them to maintain good grooming. One person said, "They get me to put my make up on, do my hair and put on my jewellery, and I feel better for it." A staff member told us how important staff felt good grooming was, saying gentlemen living in the home were encouraged to shave daily. People said staff were alert to their wellbeing. One person told us, "The staff pick up on my mood swings. If I am down, they encourage me." Where people had hobbies, these were supported, where possible. An example of this was the adapting of the lawn in front of the home to be a five hole putting green, complete with flags, for a person keen on golf.

People were supported to maintain self-care and other skills and abilities where possible. One person told us, "They have given me a Zimmer frame. It helps me to walk. I try to be independent, I dress myself and make my own bed. Staff encourage us to do things for ourselves." A second person said, "The staff encourage me to cook." Staff gave us examples of assisting with only those tasks a person could not do, such as washing their back in the bath or helping to put on tights. We noted one person still drove on a regular basis.

Where people needed support to express themselves and make decisions, but lacked family or other people to represent them, independent advocacy services were offered. These services were advertised in the entrance to the home. The acting manager gave us examples of where these had been used in the past, but told us no-one currently required such services.

The service had a policy regarding the confidentiality of people's personal information. Staff told us they were aware of this policy and told us they took care to protect such information by, for example, never discussing work issues outside the building. The acting manager told us personal information would not be given out over the phone, even to relatives, without the permission of the person. People we spoke with said they had never had any concerns regarding the confidentiality of their personal information.

Staff told us they took the privacy and dignity of people very seriously. They gave us examples of ensuring doors and curtains were closed when giving personal care; allowing people privacy in their en-suite toilets by leaving them with an alarm call; and covering people with towels whilst they prepared to take a bath. The acting manager told us privacy and dignity formed an important part of the induction of new staff. They also told us people and their relatives were specifically asked in review meetings if there were any issues regarding these areas. We observed examples of good care such as a staff member quietly suggesting to a person they might need to visit the toilet. During lunch, we saw a member of staff discretely drew one person's attention to the fact they needed to wipe their chin.

Requires Improvement

Is the service responsive?

Our findings

People told us staff were responsive to their changing needs. One person told us, "They do things the way I want." A second person commented, "If I call for the staff, they come quickly." Another person said, "They look after me very well. They do things how I want them done. I'm a very happy person and I couldn't ask for more." A third person said, "We tell them (staff) what we want and they remember."

Relatives also praised the responsiveness of the staff team. One told us, ""They move fast when the buzzer goes, and usually two staff appear." Another relative commented, "The grandchildren did not like visiting my (relative) in hospital, but they love coming here."

The acting manager told us that, where available, they received copies of any current needs assessments carried out by other professionals involved in the person's care or treatment. In addition, the acting manager carried out their own comprehensive assessment of physical needs. This covered areas including medication, pain, continence, mobility and sensory impairment. A basic mental health assessment was also carried out. We noted this did not specifically address mental capacity, at the time of admission to the service. The initial assessment was not holistic as it did not cover social, cultural, emotional and spiritual needs. We discussed this with the area manager, who agreed the assessment format needed to be revised.

Care plans had been drawn up to meet the needs identified in the assessment process. These were comprehensive and individualised to the person, but lacked focus. They did not, for example, set clear goals for the person and staff to work towards, and did not give sufficient weight to the person's strengths and abilities. Nor were they sufficiently flexible, in that there was a set range of care plan areas and no scope for addressing needs that fell outside that range. We saw there was no provision for addressing, for example, any challenging behaviours a person might exhibit. We saw staff had then tried to fit reference to dealing with such behaviours into other set care plans, meaning there was no overall, clear and coherent care planning to meet this need.

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

People's care plans were evaluated by staff every month. Evaluations were detailed and informative. Where a change of needs was identified, the relevant care plan was then updated. People's care was reviewed four to six weeks after coming into the home, to ensure the service was able to meet the person's needs; and six monthly thereafter. The person, their families and professionals were invited to attend reviews and give their views, which were documented. Where appropriate, changes were made to the person's care plans, copies of which were offered to families. A relative told us, "They listen to what we have to say in the reviews. We asked for our relative to move rooms and it was arranged for them. They go out of their way to help."

We looked at how the service handled complaints. We saw complaints records were not easily accessed, being located in a large audit file. Three complaints had been received in the previous twelve months. We found the records to be inadequate, in that the format used was too brief to allow a full description of the

complaint received or sufficient detail of the investigation and outcome of the complaint. In particular, we saw no reference to a complaint known to have been made to the local government ombudsman.

This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

An activities programme was in place. Social activities advertised included crafts, skittles, carpet bowls, card games, dominoes, karaoke, quizzes, cookery, tai-chi and film afternoons. Staff told us they regularly brought their pets to work, for people to enjoy. One person said, "I love the entertainment." People told us the staff asked for their views on activities in the service. One person commented, "They are always asking for ideas. I've suggested gardening and the theatre." This person told us they enjoyed doing some light work in the garden in the summer and that staff supported this, providing seeds and compost. Relatives told us people were supported to keep up hobbies and interests. One relative said, "They encourage my (relative)'s singing. People seem to get plenty of stimulation. There's singing, chatting, games and entertainers."

The responsibility for social activities belonged to an activities co-ordinator, as staff told us they did not have time to spare from their care duties to support the activities programme. This meant that there was some limitation in the scope of activities. The area manager accepted this and told us they were looking at ways to involve staff more in activities.

People said there were regular trips out of the home. On the first day of this inspection, we saw a party of people had been taken by minibus to a local industrial and cultural museum. Other recent trips had been to Alnwick Castle, Amble market and a theatre.

People told us they did not feel there was any danger of them being socially isolated in the home.
One person told us, "I like it here. I've got nice friends here, and more company." A relative commented, "My (relative) thinks they are at home, and that all the staff are here to care just for them, they are so attentive."

The service user guide given to people and their families promised 'an entirely flexible daily routine', with choices about every aspect of their daily lives. This included, for example, when people got up and retired, what they wore, what they ate, what activities they enjoyed and how they spent their day. People confirmed to us they had the choices promised. One person told us, "Yes, we get choice. I go to bed when I want; I get up when I want. Staff do my hair the way I want and we get choices at meals." Another person said, "We can have tea whenever we want." We saw one person asking if they could have their lunch in the lounge. This was readily agreed by the staff member.

Where people needed to transfer to other services, this was facilitated by the use of emergency health care plans and 'hospital passports'. These documents contained the information necessary to help communicate the person's needs and wishes, and ensure timely access to the right treatment and to appropriate specialists. This information included the person's underlying diagnosis, key treatments and concerns, GP contact details and whether a DNAR was in existence.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager, as the previous registered manager had left the service three months before this inspection. The deputy manager was acting as manager until a new registered manager could be recruited.

The provider has a responsibility to notify the Care Quality Commission of significant events, including any changes to the management of the service. Our records showed, however, that we had not been notified of the departure of the previous registered manager. We will be taking action in regard to this outside of this report.

A range of systems were in place for monitoring the quality of the service. These included monthly audits of cleanliness, safety, the environment, care plans, medicines, finances and accidents. Where areas for improvement were identified an action plan was drawn up, and the area manager monitored progress in meeting goals. We were given verbal and documentary evidence of the developments planned for the service. These included improving assessment and care planning documentation; introducing an administrator post and streamlining paperwork to free staff time for contact with people; and more clearly defining management roles. The area manager told us about the company that had recently been engaged to provide external audits of the service.

However, we noted that the quality systems had failed to identify or adequately address the issues in relation to staffing, safeguarding, consent, assessment, care planning, and complaints as identified in this inspection.

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

Some people felt the departure of the previous registered manager had been detrimental to the service. One person commented, "It's like a ship without a Captain, there's nobody to go to. There's lots of sorting out to do, it's not well organised." Staff, however, were supportive of the acting manager. One staff member told us, "The deputy (acting) manager has done an excellent job in meeting people's needs since the manager left." Other staff told us the acting manager was, "On the ball"; "Very fair"; "Treats everyone with respect"; and, "Clear in their expectations of staff." A relative commented on the stability of the senior staff, and told us there was good staff continuity. A visiting professional said, "Although there have been big changes to the management, there has been no obvious impact on the quality of people's care. The staff have coped very well; you wouldn't know there had been changes."

Professionals also commented positively on the communication by the acting manager and staff team. They said staff were very professional and approachable, made appropriate referrals, and followed advice given.

We found a culture of openness and transparency in the service. The acting manager and area manager co-operated fully in the inspection process, were helpful and reflective, and were honest about deficits found in

the inspection. The staff team were also open and co-operative, and there was an obvious mutual respect between them and the acting manager. We saw people felt at ease in coming into the office and were relaxed in the presence of staff.

The acting manager told us they felt supported by the provider and the provider's representatives, and could call on them for advice at any time. They told us staff worked to forge links with the local community and gave examples of good relationships with local schools and churches, and the use of young people as apprentices in the service.

Most people we spoke with were complimentary about the quality of the service. A relative told us, "It's very good. The staff team are good and work together, and we have no concerns about the management. I would put my name down to come here." None of the relatives we spoke with could think of any areas for improvement in the service.

An annual survey was carried out of the views of people and their relatives. The most recent survey had taken place in August 2015. This showed high levels of satisfaction with the care received, the catering, laundry, comfort and cleanliness of the building, and the responsiveness of staff. They also said that people's privacy and independence were respected by staff. There were no significant areas of dissatisfaction.

A staff survey also showed positive outcomes and good levels of job satisfaction. The results indicated staff were clear about what was expected of them; were encouraged to develop skills and knowledge; were committed to doing quality work; and received recognition and praise for good work. Staff we spoke with were proud of the care they provided, said that morale was good and told us they enjoyed their work.

Staff meetings were held to allow staff to express their views and receive feedback and policy updates. Separate meetings were held for care staff, kitchen and domestic staff. The minutes of these meetings indicated an inclusive culture that respected staff and valued their thoughts and suggestions.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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	Regulation 9 HSCA RA Regulations 2014 Person-centred care A full assessment of needs had not been carried out of the needs and preferences for the care and treatment of the service user. Care was not fully designed with a view to achieving service users' preferences and ensuring their needs were met. Regulation 9(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users had not been provided with the consent of the relevant person; and the provider had not acted in accordance of the Mental Capacity Act 2005. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems had not been operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of abuse. Regulation 13(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was not an effective and accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons. Regulation 16(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and improve the quality and safety of the services provided were not effective. Regulation 17(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not provided. Regulation 18(1)