Care Quality Commission

Leyton Healthcare (No 15) Limited

Ashbourne Lodge

Inspection report

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Ratings

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

Overall summary

This inspection took place on 11 and 20 August 2015. The first inspection day was unannounced, which meant the staff and registered provider did not know we would be visiting. The registered provider knew we would be returning for the second day of inspection.

Ashbourne Lodge is a purpose built care home built across two floors. The lower floor Ash unit accommodates up to 25 people with residential care needs. The upper floor is split into two units, the Cedar and the Oak. The Cedar unit offers accommodation for up to 15 people with residential care needs. The Oak unit is a dedicated dementia care unit designed for older people living with a dementia and can accommodate up to 17 people. Each unit has its own kitchenette area, where people who used the service, their visitors and relatives can make use of the tea and coffee making facilities. Each bedroom offers en-suite facilities and each unit also provides additional bathing and showering facilities. The home itself is positioned in a residential area and offers designated parking to visitors and people who use the service.

The home had a manager in place who had been working there as the manager since November 2014. At the time of inspection the manager was in the process of becoming registered with the Care Quality Commission (CQC) since May 2015. A registered manager is a person who has registered with the CQC to manage the service. Like

Summary of findings

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.

On the first day of inspection the manager was on annual leave and the deputy manager was in charge of the day to day management of the service. We found the deputy manager did not have full managerial oversight and was unable to answer questions such as how many people lived upstairs.

Staff we spoke with understood the principles and processes of safeguarding, as well as how to raise a safeguarding alert with the local authority. 14 members of staff out of 51 had not received training in safeguarding. Staff we spoke with said they would be confident to whistle blow [raise concerns about the home, staff practices or provider] if the need ever arose.

Assessments were not always undertaken to identify people's health and support needs and any risks to people who used the service and others. Plans were not put in place to reduce the risks identified. Care plans provided some evidence of access to healthcare professionals and services. Although we saw no evidence of this when people lost weight or had a fall.

There were sufficient numbers of staff on duty to meet the needs of people using the service although duty rotas showed some staff worked excessively long hours with one staff member working up to a 100 hours in seven days. Care was provided in a task focussed way. Staff were very busy on the morning and although the afternoon was a lot quieter we did not see staff engaging with people who used the service. **We recommend the manager monitors staff working hours and checks staff effectiveness and wellbeing after such long working hours to ensure the safety of both staff and people using the service.**

All of the care records we looked at contained some written consent, for example consent to photographs and to the care provided. Although not all of these forms were completed and consent was not sought for people using bed rails.

Medicines were not always managed safely. **We recommend the manager completes medicine administration competency checks, as per NICE guidelines 1.17.**

Accidents and incidents were monitored monthly but nothing was done to address patterns or themes.

We found that supervisions and appraisals had taken place and were up to date. There were gaps in training records.

We saw that people were not involved in activities. The activity coordinator had left the service the weekend before the first inspection day. The service had advertised for a new activity coordinator. Staff were not supporting with activities until this role was filled. Staff were receiving a full day of training on our first day. This was taking place in the lounge located on the Ash unit. Therefore people had no where to sit other than the corridor or their own rooms, which isolated them.

People's nutritional needs were met and their individual preferences and wishes adhered to. **We recommend the manager updates what information the cook has available.**

The service was spacious and suitable for the people who used the service. On the first inspection day some areas of the service needed a clean, for example the bathrooms had overflowing bins and air vents were covered in dust. Bedding and towels looked really worn. On the second day areas were all clean and new towels had been ordered.

We saw water temperature checks were taken regularly and the hot water did not exceed 44 degrees. However bath temperatures were not regularly recorded and when they were they were showing temperatures as low as 34 degrees. **We recommend the registered provider follows recommended guidance on safe water temperatures.**

We saw safety checks and certificates that were all within the last twelve months for items that had been serviced such as fire equipment and water temperature checks. We could not see any evidence of fire drills taking place or legionella testing.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The

Summary of findings

Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We found one person was living of the dementia unit but it was not clear whether they had a dementia type illness. The deputy manager did not have a full understanding of DoLS.

People who used the service, and family members, were complimentary about the standard of care. Staff told us that the home had an open, inclusive and positive culture.

Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible..

Care records were confusing, had limited information and were not person centred.

The registered provider had a complaints policy and procedure in place and complaints were fully investigated, although not all complaints were recorded. **We recommend the manager documents each complaint and outcome.**

The area manager carried out monthly monitoring visits. Each month they highlighted issues for example care plans need to be more person centred, care plans need more detail, no evidence of peoples capacity and no activities taking place. No action plans were put in place to rectify problems found, therefore every month the same issues were documented. We could see no learning or action plan from the monitoring visits.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Staff were knowledgeable in recognising signs of potential abuse and would report any concerns regarding the safety of people to the registered manager.

There were sufficient staff to meet the needs of the people however staff worked excessively long hours. Effective recruitment procedures were in place. Appropriate checks were undertaken before staff started work.

Risk assessments were not completed appropriately or were not in place.

Medicines were not always managed safely.

Appropriate checks of the building and maintenance systems were undertaken. Fire drills did not take place and accidents and incidents were not monitored.

Is the service effective?

Requires improvement

The service was not always effective.

Staff did not have the knowledge and skills to support people who used the service.

Formal supervision sessions and appraisals with staff had taken place.

The service did not demonstrate a good understanding of the Mental Capacity Act 2005 and DoLS, and one person was deprived of their liberty.

People were supported to have their nutritional needs met and were provided with choice.

People were supported to maintain good health and had access to healthcare professionals and services.

Is the service caring?

Requires improvement

The service was not always caring.

Peoples end of life needs were not always met.

People told us that they were well cared for. We saw that staff were caring and supported people well.

People were treated with respect and their independence, privacy and dignity were promoted.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

People's needs were not always assessed and care plans were not produced in a way that identified how to support people with their needs.

We saw that people were not involved in activities.

Appropriate systems were in place for the management of complaints. Although not all complaints were recorded.

Is the service well-led?

The service was not always well led.

Staff told us that the registered manager was approachable.

The provider did not have a robust quality assurance system in place and although gathered information about the quality of their service there was no learning or action plan taken from these.

Staff told us that the home had an open, inclusive and positive culture.

Requires improvement

Ashbourne Lodge

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 11 and 20 August 2015 and the first day was unannounced. This meant the staff and registered provider did not know we would be visiting.

The inspection team consisted of two adult social care inspectors, one specialist professional advisor and an expert by experience. A specialist professional advisor is someone who has a specialism in the service being inspected such as a nurse. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience in caring for older people living with dementia.

Before we visited the home we checked the information we held about this location and the service provider. For example, inspection history, safeguarding notifications and complaints. No concerns had been raised. We also contacted professionals involved in caring for people who used the service, including commissioners, safeguarding staff and district nurses. No concerns were raised by any of these professionals.

The registered provider was not asked to complete 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.

During our inspection we spoke with 15 people who used the service and two family members. We also spoke with the area manager, the manager, deputy manager, nine care workers, a housekeeper and the cook. We also spoke with one external healthcare professional prior to the visit.

We undertook general observations and reviewed relevant records. These included five people's care records, four staff files, audits and other relevant information such as policies and procedures. We looked around the home and saw some people's bedrooms, bathrooms, the kitchen and communal areas.

Inadequate

Is the service safe?

Our findings

We looked at what safety measures the service had in place. We looked at records to see if checks had been carried out on the fire alarm to ensure that it was in safe working order. We saw that fire alarms had been tested on a regular basis. There was no evidence of fire drills taking place. Ensuring that staff are fully aware of what must be done in a fire is vital to providing a safe environment for people who used service. We saw documentation of when the fire alarm had gone off for example due to a toaster. In April the fire alarm had sounded from the laundry, we saw staff had evacuated the building, this had then been documented as a fire drill, although no learning's were identified on how long it took to evacuate or any actions that may be required. Therefore we could not see any evidence if the evacuation was successful. We asked if people who used the service were evacuated during when the fire alarms went off, we were told for one incident people were told to stay in their rooms and for the other incident people were moved to another part of the home. However this was not documented anywhere. 25 out 51 staff had not received up to date fire safety training. This meant that not all staff were adequately prepared for a fire emergency. There was no evidence that people using the service had been involved in a full fire evacuation exercise or that they were aware of what to do in the event of a fire.

The service had an emergency and contingency plan, and Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. This meant that plans were in place to guide staff if there was an emergency.

We looked at the accident and incident records. We saw evidence that not all people who had experienced falls were risk assessed. One person who used a wheelchair for mobility had fallen a couple of times but the risk assessment in this persons care file was blank. We saw that all falls were collated each month. We could not see any learning or action from these records. For example one person had 15 falls in two months, we could not see evidence that the falls team had been asked to visit this person and there were no themes identified. For example if it had been found that the majority of the falls were happening at 5pm an action plan could be put in place to prevent or minimise the falls, such as more staff presence at that time. We discussed this with the manager and they said they would implement a learning's form immediately.

We looked at risk assessments in six care plans. Although some risk assessments were evident for example risk of social isolation, risk of refusing to shower or bath, some of these were repeated for example one person had two risk assessments for refusing to have a bath or a shower. Risk assessments were not always in place, for example one person's care file said staff were to make sure [name of person] walks with one carer and also make sure they use their stick as they are prone to falls, this person did not have a falls risk assessment. One person used an e-cigarette but there was no risk assessment regarding this. We saw one person had lost nearly 2 stone 9lbs from the 2 February 2015 to the 1 July 2015. On the 1 April 2015 this person had lost 1 stone 11lbs and it was documented on their weights records that 'X has lost nearly a stone, GP contacted who said X now needs to be weighed weekly', they were weighed again on the 14 April 2015 and had put on seven and a half pounds, they were not weighed again until 17 May 2015 and had lost one and a half pounds, the weight record stated 'X has been playing with her food and refusing to eat, to be observed.' They were weighed again on the 16 June 2015 and had lost another one and a half pounds, this time the weight record stated that 'X is to be weighed weekly requested by the memory clinic'. The person was weighed on the 22 June 2015 and had lost a further five and a half pounds, they were weighed again on 1 July 2015 and had lost 11 and a half pounds. The record stated that the GP was to be contacted regarding weight loss. Although weekly weights were requested on the 1 April 2015 this person was only weighed five times in three months. No risk assessments regarding weight loss were put in place. A nutritional assessment was completed monthly and stated usual weight, no loss. This meant that this person was in severe harm of malnutrition. This incident was referred to safeguarding. We discussed this with the manager who looked into this immediately and requested an urgent appointment with the GP. The manager said "Although no excuse we are not sure if the recordings are correct as we have one staff member who we have concerns around their skills to weigh people." We asked why this person was still allowed to weigh people but the manager could not answer this. Another person's care file showed they had not been weighed since

Inadequate

Is the service safe?

November 2014 and every month it was documented that X (persons name) will be weighed when the district nurse gets the scales. The manager said due to this persons posture it is difficult to weigh them. The manager had not sought any alternatives or advice on how to do this and the same sentence had been written in the care file for nine months.

Another person's risk assessment said, "X likes to move around and staff were to remove any obstructions in their pathway." We observed this person sitting in the upstairs lounge by themselves on both inspection days, with a table placed in front of them. We questioned why the table was there as it could be classed as a form of restraint. The senior staff member said they like the table there and it was that persons choice. We could not see this documented. This person was very hard of hearing, therefore could not hear when we asked if they were happy to have the table in front of them. There was no risk assessment regarding this persons communication abilities and lack of hearing. One person had a condition called oespohagitis which is an inflammation of the lining of the oesophagus, the tube that carry's food from the throat to the stomach. This can cause many symptoms including difficulty in swallowing, there was no risk assessment in place for this. One care plan we looked at was for someone who was an insulin dependent diabetic and prone to hyperglycaemic episodes at night again no risk assessment was in place. Hyperglycaemia occurs when people with diabetes have too much sugar in their bloodstream. This person also had a post fall observation sheet in place, but no falls risk assessment was in place.

This was breach of Regulations 12 (2) (a,b) (Safe care and treatment); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with said they felt safe living at the service. One person said, "I have been in a while. Yes I feel safe." Another person said, "I am safe, Staff respond quickly if I use my call bell and are always pleasant even when very busy."

We looked at the arrangements that were in place for ensuring cleanliness and infection control. We found that the main communal areas of the home were clean and free from unpleasant smells. We saw that gloves and aprons were available throughout the home and staff we spoke with confirmed that they had access to these items when needed. We also saw staff using gloves and aprons throughout our visits. However on our first day of inspection we saw bathrooms had bins that were overflowing, the ventilation fans were thick with dust, shower drains looked old and discoloured, full or half full laundry skips were placed in the bathroom and shower chairs had what looked like dried faeces underneath. Cleaning rotas placed in the bathroom were not completed and personal toiletries were stored in the pad cupboard. A stairwell was full of clutter despite signs saying nothing to be stored there. We discussed this with the area manager who acted on this immediately. The second day of inspection all bathrooms were clean and tidy and the stairwell cleared. We looked in the linen cupboard on the second day of inspection and found linen and towels were not stored neatly and bedding was pushed in at the bottom which meant they were on the floor. Towels and bedding looked old and worn. The area manager arranged for the cupboard to be tidied and ordered in new towels whilst we were still there.

We saw water temperature checks were taken regularly and the hot water did not exceed 44 degrees. However bath temperatures were not regularly recorded and when they were they were showing temperatures as low as 34 degrees. A bath should be about 2 degrees higher than body temperatures so about 39 degrees. 34 degrees may have made the bath too cold therefore uncomfortable. **We recommend the registered provider follows recommended guidance on safe water temperatures.**

During our two day inspection we spoke with 12 members of staff. Every staff member said that they felt they were short staffed. One staff member said, "We often don't have time to take our full half hour breaks, we need more help, call bells will go off when you are dealing with other people, you either have to leave who your with or ignore the call bell which means we are not meeting people's needs." And "I sometimes have to leave people in an undressed state, I will cover them but I feel awful because I am knowingly leaving people." Another staff member said, "The manager seems to understand but the company don't listen when we ask for more staff." And another said "I personally say we don't have enough staff I know that the dependency tool says we do but there are lots of residents with a lot more needs." Staff we spoke with felt the home would benefit from a 'floating' staff member to add to the numbers and go to wherever the need was greatest at the time.

Inadequate

Is the service safe?

We looked at staff rotas and saw there was one senior and 2 carers working on the residential unit downstairs where 20 people used the service and there was one senior and three carers overall on the two units upstairs, one residential with 13 people and one for people living with a dementia and there were 11 people living on this unit. The dependency tool the service used showed they had enough staff. We were concerned that a few members of staff were working from 8am to 10pm, 14 hour days with two half hour breaks. One staff member worked seven of these shifts in concession plus 2 other shifts. We asked the manager what they had done to ensure that this person was still fit and able to carry out safe care after working 98 hours without a day off. The manager said it was this persons choice and they felt they were fine and able to provide safe care. We asked to see evidence of a discussion between the manager and this staff member that had ensured they could provide safe care and for the staff members own personal wellbeing but nothing was documented. We discussed these hours with the staff member and they said they have no issues working long hours and it is their choice. Another person who had done these hours once or twice said, "They are brutal, sometimes you don't have time for a drink." They also said, "During the 14 hour shift I get two half hour breaks but it is sometimes hard to get your breaks as a senior and I have worked shifts when I have not had these two half hours." Another staff member said, "I love it here, I love my job, I love the residents. Sometimes we're knackered and don't want to have to pick up extra shifts, more staff would make all the difference and give us more time to spend with people." We asked the manager and area manager if the staffing levels matched the dependency tool due to people working extra shifts. We were told that they do have a vacancy for a carer's role but were struggling to fill this. **We recommend the manager monitors staff working hours and checks staff effectiveness and wellbeing after such long working hours to ensure the safety of both staff and people using the service.**

We looked at staff handover records. These records did not have a lot of information documented for example it would state no concerns. We were told that the senior carers were paid to come in quarter of an hour early each shift to receive the handover. Other staff members did not receive this handover and were 'sometimes' given a brief outline from the senior if the senior had time. Therefore staff were not fully informed on any relevant information on what had happened on the previous shift and what was to happen on the upcoming shift. We discussed this with the manager and area manager. The manager said they are all welcome to come in quarter of an hour early to receive the handover. The manager and the area manager agreed everyone should attend the handover and would look into how they would do this.

Staff we spoke with during the inspection were aware of the different types of abuse and what would constitute poor practice. Staff told us they had undertaken training in safeguarding and were able to describe how they would recognise any signs of abuse or issues which would give them concerns. They were able to state what they would do and who they would report any concerns to. Staff said that they would feel confident to whistle-blow [telling someone] if they saw something they were concerned about.

The management team had worked with other individuals and the local authority to safeguard and protect the welfare of people who used the service. Safeguarding incidents had been reported by either the service or by another agency. Incidents had been investigated and appropriate action taken.

We looked at the recruitment records for four members of staff and saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS) checks were carried out. DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. We saw at least two written references were obtained, including one from the staff member's previous employer. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and that any gaps in employment history had been suitably explained.

We looked at the management of medicines. On the first day we observed a lunch time medicines round. We saw the senior carer popped the medication from the blister packs into a medicine pot, we did not see the senior carer check the MAR chart or look at the dispensing label. If any medication had been put on the rack incorrectly this would not have been identified and incorrect medications would have been administered. One persons morning medicines

had been prepared and the senior had realised that they were still in bed, they put this to one side to be taken at lunch time. The senior had signed to say this medicine had been administered, even though it had not. This meant that this person was at risk of not receiving their prescribed medicines. The senior also prepared another person's medicines then looked up and realised they were eating their lunch. The senior said that this person refused to be interrupted during a meal and she would have to administer them later. This meant again medicines had to be stored in a medicine pot that had no identification on. **We recommend the manager completes medicine administration competency checks, as per NICE guidelines 1.17.**

We saw medicine administration records (MAR) were on the whole complete. Stock levels were fine and re ordering procedures were in place. We did see information in one care file stating that this person was allergic to Citalopram, the care plan summary sheet stated no known allergies and the MAR chart did not reflect this allergy. We questioned this with the senior carer who informed us that new cover sheets had been produced but were not on file. The allergy notification had been received from the GP on the 9 April 2015 and four months later the care files and MAR chart had not been updated. This meant that the person was at risk of receiving a medication they were allergic to due to records not being updated in a timely manner.

We saw no evidence of 'when required' (PRN) protocols in place. These provided guidance about how and when a PRN medicine would be administered.

Medicines were kept securely. Records were not always kept of room and fridge temperatures to ensure they were safely kept. At one point the room recording went up to 31 degrees, recommended temperature is not above 25 degrees. We could not see any evidence of what action the service had done about this. We found one medication stored at room temperature that should have been stored in the fridge.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.

We saw safety checks and certificates that were all within the last twelve months for items that had been serviced such as fire equipment, lift and hoists. We saw that the water temperature of

showers, baths and hand wash basins in communal areas were taken and recorded on a weekly basis to make sure that they were within safe limits. We saw no evidence of legionella testing, the last test had been carried out in 2011.

We looked at records which confirmed that checks of the building and equipment were carried out to ensure health and safety. Although the cluttered stairwell had not been identified. We saw documentation and certificates to show that relevant checks had been carried out on the gas boiler, fire extinguishers and emergency lighting. Portable appliance testing (PAT) was taking place at the time of our inspection, this is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. On the first day of inspection we were told that six people had a DoLS in place but the DoLS file said there were nine. One person was living on the unit for people living with a dementia type illness but it was not clear whether they had a diagnosis of dementia. We asked why they were living on this unit and the deputy said, "Well they were becoming unmanageable and refusing showers." Then quickly added, "It was their choice to live there." We asked if this person had capacity and were told yes, we then asked if they were free to leave the unit whenever they wanted and we were told no they were not. We explained if this person has capacity they were depriving them of their liberty as they were not free to leave when they wanted. The information the deputy manager provided did not seem to be an explanation of why the person made the choice but more of a reason why the service had decided they would move onto the dementia unit. The deputy manager did not seem to fully understand DoLS, they had received training a year ago and were booked in for refresher in August 2015. We looked in this persons care file, this provided conflicting information. A document which was completed on the day of this persons admission on the 18 October 2008 gave the reason for their admission as 'unable to cope at home' there was no information given under the heading 'diagnosis'. A letter from Stockton Borough Council at the time of their admission stated that because of their Mental Health they were in need of EMI (elderly mental ill) care and were to be admitted to the service under the Care in the Community Scheme. This information did not seem to have been accurately picked up on or recorded in the home's pre-admission documents.Throughout the care plan it would say X (persons name) has capacity to make decision, then the next page it would say X does not have capacity to make decisions. No capacity assessment had taken place. We questioned this with the manager and they said they were told from the LA to put DoLS requests in gradually. The manager put this through as an urgent request on the second inspection day.

This was breach of Regulations 13 (5) (Safeguarding service users from abuse and improper treatment); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with six staff to test their understanding of DoLS, only one staff member had a clear understanding. We discussed this with the manager who was going to address this. We looked at training for MCA and DoLS and 38 members of staff had not received recent training.

We asked staff about their most recent training and one member of staff said "We get lots of training, I have just done manual handling, food hygiene and infection control."

We asked to see the training chart and matching certificates. The majority of training was out of date, although some training stated it was to be completed yearly and the training chart showed for a couple of staff that they had not done some training since 2011 and others were blank, therefore we could not see if they had ever received training. For example one staff member last had fire training in 2011, moving and handling in 2013, food hygiene in 2003, health and safety in 2001 and safeguarding in 2012, they had received training in infection control and first aid. The manager and area manager explained they were aware of this and had training booked into cover the shortfalls, although recent training for control of substances hazardous to health (COSHH) had been cancelled. We asked staff about how their competencies were assessed as well as the frequency. They told us they did not receive competency assessments. The manager said competencies had not taken place but they will start these and document them immediately.

This was breach of Regulations 18 (2) (a,b) (Staffing); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who used the service if they felt staff were well trained and knew what they were doing. One person told us; "I love it here, the staff are great, very pleasant and I am well looked after. The food is also good." Another person said, "All staff are helpful." A relative told us, "My relative is not well but the staff have been very good. The doctor is visiting regularly and I am comfortable they are being well looked after".

Requires improvement

Is the service effective?

Staff we spoke with said, "I love my job and the home, I don't like the company. They don't consider the staff and think about money, sometimes we have to ask and ask for things like a hoist when it is needed." Another staff member said, "I enjoy coming to work."

We looked at staff induction. We were shown the 'staff induction sheet', which included the philosophy of the service, the rights of people who use the service, the policies and procedures of the service, action to be taken in an emergency and personal conduct. Staff told us that for one person who had recently started at the home they would be undertaking the 'Care Certificate' and they duly showed us the care certificate file for the member of staff. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Designed with the non-regulated workforce in mind, the Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

All staff we spoke with said they had regular supervisions with the manager. One staff member said, "I find the supervisions very supportive." We checked four staff records to verify that supervisions had been carried out every six to eight weeks, as documented in the supervision agreement and saw supervisions had been conducted for staff. We saw supervisions contained the following areas: documentation, medication, team working, time management, organisation skills, communication, personal issues, targets and objectives, policy checks, employee comments, employee signature, manager's signature, action points and timescale. We were also told that appraisals took place annually and we saw evidence of this.

We also saw records of other regular staff meetings and staff told us about the most recent meeting in June 2015 which they felt was very productive. One staff member said, "The last staff meeting was very good, the manager addressed issues that were present at the time." Another staff member said, "We get the chance to voice our opinion, head office don't listen though."

We observed the lunchtime meal in all three dining rooms. Most people felt the food was very good although it could be repetitive. One person said "The food is fine, I get a choice at meal time and there is plenty to eat." Another person said "You really get too much to eat but the food is always hot and tasty." And another person was not keen on the food at all and said, "The food is crap in here." Staff said they feel the food could be improved, one staff member said, "The food is very bland and they get the same sandwiches every tea time, the sprouts today looked like they had been cooked for a week." Another staff member said that people had asked for ice cream at lunch time, it was a warm day and they did not want sponge and custard. The staff member went to the kitchen to request about six bowls of ice cream and was told no by the cook, who stated "I have been told I am giving too much ice cream." The staff member would not take no for an answer and made sure the people who used the service received their request. We discussed this with the manager who was going to look into it.

Some people opted to have meals in their room purely from personal choice. Staff who took the meals to the rooms did not use plate coverings. The dining rooms on the residential care units were well presented. However the dining room on the dementia unit was not set out as attractively Here the tables only had a place mat, knife, fork, spoon and serviette set out. A drink was offered when someone sat at a table. When we asked about this we were told "It is in case people throw things around." During our time on the unit we did not see any evidence of behaviour's which would warrant such a view. People were offered a choice of meal at the table, either sausage with vegetables or chicken pie followed by sponge pudding or alternative. On the dementia unit people were asked what they wanted but were not shown a choice either by the meals being on a plate to view or a pictorial view. As dementia progresses a person may have difficulty choosing and deciding on the food they want to eat. Simply calling out a list of options can be confusing and difficult for the person to understand as they may no longer recognise what the food is from hearing the words alone and may struggle to remember all the options given to them.

If the person can see the food this will help them recognise it and make a choice. We passed on this information to the manager.

On the first day of inspection menus were not displayed in prominent places. For example outside the lifts upstairs in a foyer that no person who used the service ever frequented. The menus were small and displayed as week one to four but no explanation as to what week it was. The

second day the area manager had arranged for menus to be displayed outside each dining room they said these were just a quick fix and wanted to make further improvements such as add pictures.

We spoke with the head cook who told us they were informed about anyone with any special dietary needs by the care staff. We looked at the records they kept but some information did not correspond what we had seen in peoples care files. **We recommend the manager updates what information the cook has available.**

We saw records to confirm people had visited or had received visits from the dentist, optician and their doctor. However some specific requests were not being met. For example, it was suggested that one person get a hearing test and see a chiropodist and we could not see evidence of this taking place. We also could not see if healthcare professionals were contacted appropriately around falls and weight loss.

Not everyone signed to show their consent and involvement in their plan of care, some care files were signed by a care worker but had no explanation to say why the person had not signed. Consent was not sought for everything such as the use of bed rails.

We looked around the premises and found the communal areas were nicely decorated and corridors were wide. There was no designated smoking area for people who used the service and they were having to go outside one of the entrances for a smoke. We were told by people that they had to go outside regardless of the weather and there was only a slight overhang from the roof to protect them from bad weather. On the first day of inspection the entrance had a lot of cigarette ends lying about, this had been cleaned up when we returned. On the first inspection day the downstairs lounge was being used for dementia training. This meant people who used the service had no where to sit and although some sat outside the majority spent this time alone in their rooms. One staff member said, “Staff training takes place about once or twice a month and it is always in the ground floor lounge. “They acknowledged that adjustments could be made to ensure people’s routine was not affected by this. They admitted that one person shouts because they are bored and it can be isolating when their choice to sit in the lounge is taken away. We discussed this with the manager and area manager, who said they were aware that it is not ideal and would make sure an alternative location would be sought.

On the first day of inspection we found no dementia friendly signage, the area manager had made some laminated signs that were on display our second day. We discussed the need to improve this unit with the manager and area manager and they said they have ordered different coloured crockery and dementia adaptations

Requires improvement

Is the service caring?

Our findings

People we spoke with said they were happy with the care that was provided. People who used the service and their relatives felt they were well cared for and cared about. One person said, “The staff are kind and considerate and nothing is a trouble.” Another person said, “You get friendly with the staff so you can talk to them without feeling uncomfortable.” A visiting hairdresser we spoke with said, “This is a very happy home.” And “Staff have a nice relationship with everyone.” The hairdresser also sat with people on a lunchtime chatting to and supporting people.

Staff we spoke with said, “I love it here, I love caring for the people who live here.” Staff could easily explain about people who they were key worker for.

On the first day of inspection we asked the deputy manager if anyone was on end of life care. We were told that one person was on end of life care and was awaiting an assessment regarding a move to a nursing care provider. There was some confusion later in the day as to this person’s needs. It was not clear whether they were on end of life care, palliative care or neither. There was no end of life care plan in place. On the dependency chart provided by the service they were identified as ‘low risk’ of end of life care. This meant that there was clearly a need for urgent clarification of this and it indicated a lack of awareness regarding the care needs of at least one person using the service. We found out on the second inspection day that this person was not on end of life but had since had a fall and been taken to hospital and then would require nursing care, therefore would not be returning to the service.

We did see some end of life preferences and wishes documented in care plans. We also saw these were evaluated every month. We saw information where people had been asked their wishes every month and the documented response was ‘they do not wish to discuss this subject.’ We discussed the need for this conversation to be taken every month if people clearly don’t want to talk about it and it could be quite upsetting for them. The manager said she would look at this and put in place an annual or six monthly review depending on the person.

We saw staff treated people with dignity and respect. We asked staff how they ensured that people’s dignity was maintained. One staff member said, “I keep doors and curtains closed, I ask permission before carrying out any personal care and I always keep their dignity by keeping them covered and helping them dress quickly.”

We observed during the visit that care staff were friendly and caring with people when supporting them. We spent time observing how staff supported people living at the home and found that staff were respectful in their approach, treating people with dignity and respect. We observed staff knocking on doors and waiting before entering, ensuring people’s privacy was respected. We did observe staff listening to what people were saying but they were not sitting talking to people or engaging in some activity.

The environment supported people's privacy and dignity. All bedrooms were for single occupancy. The majority of people had personalised their rooms and brought items of furniture, ornaments and pictures from home. People had choice whether they wanted a key to their room or not.

We saw that staff did try to promote independence by asking people if they could manage things for themselves such as cutting up food, going to the toilet, going out into the garden area on their own. One staff member said, “I promote independence by allowing and encouraging people to do things for themselves, we try our best to get people involved in every day things.” They described how one person goes out for a walk every night.

We asked the manager if people had access to an advocate. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. We could see to no evidence of advocacy on display. The manager said, “I will Google this and find out.” The manager had printed off some information on available advocates, which was on display by the end of inspection.

Requires improvement

Is the service responsive?

Our findings

During our visit we reviewed the care records of five people. The care plans were found to be badly organised, difficult to follow and gain an overview of people's needs, they did not contain all the necessary information in relation to the individual.

Examination of care plans showed they were not all person centred. Person centred planning (PCP) provides a way of helping a person plan all aspects of their life and support, focusing on what's important to the person. We found photocopies of risk assessments where the care worker only had to add a persons name and room number by hand, therefore these were not person centred or tailored to meet the individual's needs.

One care file we looked at had a skin assessment and body map dated 25 June 2015 stating grade three on left ankle. No other information was completed, there was no name of the form and if the form became detached from the care file there would be no means of identifying who it belonged to. Another person care file had forms from a previous respite visit in November 2014, no updated paperwork had been completed when they were re admitted. This meant that people may not have been consulted about their care and the quality and continuity of care may not have been maintained.

We were told that care files were reviewed monthly, we saw the majority of the reviews said no change. We saw a sheet on the wall that said 'care files to be evaluated immediately.' The list had some names with dates next to them to say they had been evaluated but other care files had been waiting for a least a month to be evaluated immediately. Another care file had post it notes stuck on the front which stated a bed rail assessment and bed rail care plan was needed. This was dated 16/04/2015. There was still no bed rail assessment or care plan although the person was using bed rails.

One person's care file had a communication care plan it stated that there was 'no problems' with a note that there were 'some hearing problems if not facing X' (persons name). We spoke with this person during our inspection and their hearing loss seemed to be quite substantial causing real difficulty when trying to communicate with them. There was no record of this person wearing hearing aids or having had a hearing test despite this having been recommended at a reassessment review of service meeting with Stockton Borough Council and North Tees PCT dated 13 November 2014.

We saw daily care notes were not completed everyday. For example each person had a daily hygiene sheet, carers would sign to say what had happened that day. Some records indicated that people were only washed once or twice a week. People looked clean and tidy and no one living at the service raised concerns, therefore this was record keeping. Another person was on a fluid balance chart and some days nothing was recorded and others only two cups of tea. We discussed this with the care workers and they said they often struggle as all care records are locked away and the senior is the only one with a key. If the senior is busy with a GP or district nurse, they cannot access these files therefore daily care notes cannot be updated. We discussed the inability to access and update files with the manager who said she would look into making files more accessible.

Daily records for one person had incorrect information. It stated that the district nurse had checked X (persons initials) and no concerns. Unfortunately the initials did not match the persons whose file it was. This meant that staff may not be up to date with the changing needs of people who lived there. Another persons care file had daily notes belonging to someone else.

Another person had a catheter in situ, they recorded the output daily and most days it was 1000ml but on one day the output was only 200ml. There was nothing documented to say why such a low output and if anything had been done about it. We questioned this with the manager who was not aware but would look into it.

We saw pressure relieving equipment was being used such as an airflow mattress. People using an airflow mattress had no care plan in place and no checks were done on the mattresses to see if they were set correctly for the person using them or still working and in good clean order.

We asked staff if they read the care plans and every staff member we spoke with said no. One staff member said, "I make time to update my care plans, the ones I am responsible for. I think it would benefit us to look through

Requires improvement

Is the service responsive?

care plans, if I have been off and a new person comes to live here I don't know their needs I have to rely on others." Another staff member said, "I don't have time to read the care plans."

This was breach of Regulations 9 (1,3) (Person centred care); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see some 'this is me' booklets completed which gave an interesting highlight into peoples pasts and a typical day and life history sheet had been compiled.

We were told the activity coordinator had left the Sunday before our first inspection day. On both inspection days no activities were taking place. Due to staff using the lounge on the first day people had no where to sit and mainly stayed in their rooms. Some people sat outside chatting. People we spoke with said, "Nothing much goes on." Another said, "I just amuse myself." Another person said, "Well we may get a game of bingo or a quiz." A visitor we spoke with said, "There is little if any stimulation on this dementia unit."

There was an activities programme on display but it was for July. Since the activity coordinator left that everything had stopped and staff were not encouraged or enabled to make time to start an activity. Staff we spoke with said, "I started a jigsaw with someone the other night, we arranged all the pieces and then I got called away, when I came back someone had tidied it away, I was really upset." Another staff member said, "People look lonely but we cant make time, I would love to spend half an hour doing karaoke or a quiz but cant."

We saw staff completing daily notes but rather than sit with people to do this they sat in the dining room. We discussed this with the area manager who said, "I noticed this and asked the staff to sit with people to complete these."

We looked at the home's complaint procedure, which informed people how, and who to make a complaint to and timescales for action. We saw they had received three formal complaints over the last 12 months, two of these were about a previous member of staff. Another complaint had been documented correctly. We were told about a complaint from a relative stating they are waiting for the manager to arrange an appointment. There was nothing documented in the complaints file. We discussed this with the manager who gave an explanation of where the complaint was and how it was sorted. **We recommend the manager documents each complaint and outcome.**

Requires improvement

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a manager in place. They were in the process of being registered with the care quality commission..

At the inspection the manager told us of various audits and checks that were being carried out and provided evidence of these. These included audits of the kitchen, infection control, laundry, maintenance, staffing and medication. The majority of audits were just a tick sheet and no action plans were put in place. The audits had not picked up and actioned the issues we identified, if the audits had been more robust they would have been picked up well in advance. We discussed this with the manager who said they have changed the sheet and it now includes an action plan.

The area manager carried out visits to the service on a monthly basis to monitor the quality of the service provided and to make sure the service was up to date with best practice. Records were available to confirm that this was the case. We saw records for May, June and July 2015 from the area manager who was in place now. Every audit stated that care plans were not up to date and were basic, needing more information. We discussed this and said due to their being no action plan each month they were finding the same issues. The area manager is now also incorporating an action plan into their audits with dates of when things needed to be done by.

We asked staff what they thought of the manager. Staff we spoke with said, “The manager is lovely, brilliant, I think they struggle as been thrown in at the deep end and some staff are judgemental and cliquey.” Another staff member said, “The manager is supportive, I don’t think she gets support from above.” And another said, “The manager is absolutely brilliant, really good and very approachable.”

Due to the manager being on holiday the first day, we left some questions for them to answer about links with community and how they promote the services visions and values. We said they could think of what they wanted to say and email their answers over. Unfortunately we never received a response.

We asked staff about the culture of the service and one staff member said, “We have an open and honest culture, if anything is going on we get told about it and any changes we are made aware.”

We saw no evidence of meetings for people who used the service or their relatives. We were told that the activity coordinator conducted these meetings but were unable to find any meeting notes. People we spoke with could not recall any meetings.

The manager sent out surveys to relatives, people who used the service in January 2015. Comments made on these forms were clothing going missing, complaint about food, staff morale is low, head office should listen to staff, staff look tired and staff sometimes work as a team and the care is exemplary. We asked the manager what had been done about these comments and were told they had not been collated or acted upon.

A survey had gone out to healthcare professionals and they had received two back which just stated no concerns.

This meant that although the manager had questioned the practice and quality of the service, there had been no action plan or learning put together from peoples responses. Between the two inspection days the manager had sent another survey out and said they would be acting on it once they had all been returned.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The provider had not always informed CQC of all significant events that happened in the service in a timely way. We discussed this with the manager who said they would make sure they kept CQC informed of everything they needed to.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment This was breach of Regulations 13 (5) (Safeguarding service users from abuse and improper treatment); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: People were being deprived of their liberty and DoLS were not in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing This was breach of Regulations 18 (2) (a,b) (Staffing); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: Staff were working excessively long hours and were not adequately trained

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care This was breach of Regulations 9 (1,3) (Person centred care); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: Care files were not person centred, confusing and had limited information

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 This was breach of Regulations 12 (2) (a,b) (Safe care and treatment); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: Risk assessments were not always completed or in place

The enforcement action we took:
A warning notice was issued.