Gainford Care Homes Limited

Lindisfarne House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection which we carried out on 19 April 2016. We inspected the service to follow up on the breaches and to carry out a comprehensive inspection.

We last inspected Lindisfarne House in February 2015. At that inspection we found the service was in breach of its legal requirements with regard to Regulation 12 and Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. This was because records were not in place to ensure people were protected from unsafe care as risks to people were not always accurately recorded. Records did not contain all the information to ensure people received appropriate care that met their needs.

Lindisfarne House is a purpose built care home that provides personal and nursing care to a maximum of 60 older people, including people who live with dementia. This also includes 15 younger people who have physical disabilities.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

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

We found improvements had been made with regard to record keeping to ensure people received care and treatment that met their needs.

People told us they were felt safe. However, staffing levels were not sufficient to ensure people's needs were managed safely at all times. Staffing levels were increased as the result of our inspection but they needed to be consistently maintained.

Systems were in place for managing and mitigating risk. A more critical accident and incident analysis was introduced that needed to be maintained and regularly reviewed to identify any trends of accidents and incidents that occurred to help prevent them occurring.

Risk assessments were in place and they accurately identified current risks to the person. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. People received their medicines in a safe and timely way.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed.

Records had been updated and they were regularly reviewed to reflect peoples' care and support requirements. Staff knew the people they were supporting well. Care was provided with kindness and people's privacy and dignity were respected.

Staff had received training and had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves.

Staff received other opportunities for training to meet peoples' care needs and in a safe way. A system was in place for staff to receive supervision and appraisal.

Menus were varied and a choice was offered at each mealtime. Staff supported people who required help to eat and drink and special diets were catered for. Activities and entertainment were available for people and people were being consulted to increase the variety of activities and outings.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. People had the opportunity to give their views about the service. There was regular consultation with people or family members and their views were used to improve the service. The provider undertook a range of audits to check on the quality of care provided.

The environment was mostly well-maintained for the benefit of people who used the service.

Staff and people who used the service said the manager was supportive and approachable. Communication was effective, ensuring people, their relatives and other relevant agencies were kept up to date about any changes in people's care and support needs and the running of the service.

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

Not all aspects of the service were safe although improvements had been made.

Improvements had been made with regard to record keeping to ensure people received safe care and treatment and distressed behaviour was better managed.

People told us they felt safe however staffing levels were not sufficient to ensure people were kept safe. People received their medicines in a safe and timely way.

Systems were reviewed and a falls protocol was in place to protect people who were at risk of falling.

Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

Is the service effective?

Good

The service was effective.

Staff received the training they needed and regular supervision and appraisals.

People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment.

Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care. Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received food and drink to meet their needs and support was provided for people with specialist nutritional needs.

The environment was showing wear and tear in some areas of the home.

Is the service caring?

Good

The service was caring.

Staff were very caring and respectful. People and their relatives said the staff team were kind and patient as they provided care and support.

Staff were aware of people's backgrounds and personalities. This helped staff provide individualised care to the person. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

People were encouraged and supported to be involved in daily decision making.

Is the service responsive?

Good

The service was responsive.

Improvements had been made to record keeping. This meant people received support in the way they wanted and needed because staff had detailed guidance about how to deliver their care.

People were provided with some activities and the programme was being expanded and developed by the new activities person. People had the opportunity to access the local community.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff and relatives told us the registered manager was supportive and could be approached at any time for advice and information.

The home had a quality assurance programme to check on the quality of care provided.

Improvements had been made by the provider and registered manager to promote the delivery of more person centred care for people.

Lindisfarne House

Detailed findings

Background to this inspection

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

This inspection took place on 19 April 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR 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 as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams. We also contacted health and social care professionals who worked with the service. We received no information of concern from these agencies.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with nine people who lived at Lindisfarne House, six relatives, the registered manager, two registered nurses, eight support workers including one senior support worker, the activities organiser, two members of catering staff and two visiting health care professionals. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care records for seven people, recruitment, training and induction records for four staff, seven people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people

who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we had concerns assessments were not up to date to reflect any risks to the care and treatment of people. We also had concerns people did not always receive the appropriate care to ensure their safety and welfare. We had found records were not regularly evaluated to ensure any changes in need were taken into account to reduce the risk to the person and they did not reflect current risks to people's well-being.

At this inspection we found that improvements had been made. Individual risk assessments were in place and there was a system of regular review to ensure they remained relevant, reduced risk and kept people safe. Evaluations included detail about the person's current situation. The risk assessments included risks specific to the person such as for moving and assisting, mobility and pressure area care. However, we had concerns about the number of accidents and incidents as five people had fallen and broken a femur or pelvis. We were aware two people had fallen in one week and broken a limb and discussed with the registered manager the arrangements that were in place to keep people safe. Some arrangements were in place, such as the use of sensor mats to alert staff when people who had been assessed as being at high risk of falling, may be trying to move without support. We were told incidents were analysed by the manager at the home. We considered there needed to be a more thorough audit of individual accidents and incidents to look for any trends. Measures needed to be put in place to reduce the likelihood of these incidents occurring and to make sure any learning from incidents took place with staff. An analysis to include time of incident, place, staff deployment at the time and review of a person's medicines. The registered manager told us this would be addressed and each person in the home would have a mobility and falls risk assessment carried out again to check for any current risks and a new falls protocol was to be introduced which we received after the inspection.

We were told staffing levels were determined by the number of people using the service and their needs. However, we considered there were insufficient numbers of staff available to keep people safe at the current time although we had received some positive comments about staffing levels. Peoples' comments included, "As long as nothing goes wrong we've enough staff," "I feel safe, I can usually get hold of someone," and, "I feel safe, too safe if anything, can only go downstairs with staff, and, "Staff levels are manageable, they're not generous," Staff comments' included, "I think there are enough staff," and, "Yes, we're okay." Relatives' comments included, "There are always staff around," "I've never seen it when staff haven't been in," and, "People are on hand." We noted the staffing levels had decreased since the last inspection although occupancy levels and peoples' needs had increased, there had previously been two nurses and 12 support workers to assist 45 people.

At this inspection there were 51 people who were living at the home supported by two nurses and ten support workers. Staffing rosters and observations showed on the top floor 14 people, most of whom required two staff members to assist them because of their physical dependency were supported by three support workers including a senior support worker and a nurse who also covered the lower ground floor. On the ground floor 23 people who lived with severe dementia and needed full staff support for all their needs were supported by four support workers and a nurse. On the lower ground floor 14 people were supported

by three support workers, including a senior support worker and a nurse who also covered the top floor. These numbers did not include the registered manager who was also on duty each day. Overnight staffing levels included from 8:00pm until 8:00am one nurse, one senior support worker and six support workers. After the inspection we were told arrangements were in place for a staff member to start work at 6:00am until an additional member of night staff was recruited. This meant night staffing levels were to increase to seven support workers, one senior support worker and a nurse on duty to provide supervision and care and support to people.

Our observations at the lunch time meal and the numbers of accidents and incidents with people did not show that sufficient staff were available to supervise people and keep them safe.

There had been some improvement to people's mealtime experience due to the deployment of staff. The chef remained and served the meals from the hot trolley on the ground floor. This left other staff free to assist people who required support. However, we considered that further improvements could be made to the meal times to the ground and top floor of the home. Meals were served in two 'sittings' with more dependent people receiving their meal first, some people had meals in their bedrooms and required staff support. On the ground floor we observed some people left the table before they had finished their food and as staff were busy it was difficult for them to monitor what the person had eaten or to encourage them to finish their meal. Staff were not available to supervise and provide support to people as they waited for their meal in other areas. This meant some people who were mobile and walked along the corridors were unsupervised. We intervened on the ground floor as staff members were busy, as we observed a person undressed and was incontinent in the hallway and some people who were in the area were at risk of slipping as they walked around. Staff who were assisting people to eat also responded to buzzers from people calling and had to intervene and leave people midway through giving them their food. On the top floor, although staff members were in the same room assisting people to eat, they had their back to the dining area, and were not immediately aware of a person who had accidentally started to choke on something they were eating. A member of staff attended immediately and cut the person's food up and sat with them to provide re-assurance. We were told the person was not usually at risk of choking.

We discussed our findings with the provider and registered manager who told us this would be addressed immediately. We were told there were usually more people to assist at meal times. A volunteer usually helped with the lunch time meal and assisting people with their meal but they were not available on the day of inspection. Arrangements would be made for the activities organiser to also become involved and help support people who required assistance with their meal as they were not providing social activities during meal times. This additional support would help improve peoples' mealtime experience and ensure enough staff were available to provide supervision during meal times.

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

After the inspection we were told staffing levels had been addressed as the number of support workers had increased to twelve staff to ensure people's care and support needs were met more safely at other times of the day. However, staffing levels needed to be consistently maintained to ensure they met people's needs.

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. A senior person told us, "We audit service user incidents. If there were more than two or three with the same person we would get someone else such as the psychiatrist or behavioural team involved to give advice." We

viewed the safeguarding records and found concerns had been logged appropriately by the registered manager. 26 safeguarding alerts had been raised since April 2015. They had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns. The information had been shared with other agencies for example, the local authority safeguarding team.

We found improvements had been made to assist staff with the management of distressed behaviour which some people displayed. Records were now in place for the management of this behaviour which could be challenging. Care plans gave staff instructions with regard to supporting people if they became agitated or distressed, with details of what might trigger the distressed behaviour and what staff could do to support the person. This guidance helped ensure staff worked in a consistent way with the person, to help reduce the anxiety and distressed behaviour. Care plans were in place to show peoples' care and support requirements when they became distressed or agitated and they were regularly updated to ensure they provided accurate information.

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the department of psychiatry of old age and the community mental health team. Staff told us they followed the instructions and guidance of the community mental health team for example to complete behavioural charts if a person displayed distressed behaviour. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known.

We checked the management of medicines and found previous concerns had been addressed with regard to the use of 'when required' medicines which may be required when people were in pain or agitated or distressed. Detailed information and guidance was now in place for each person to help staff support them if they were agitated or distressed. We were told this guidance was followed to try to calm people before any sedative medicine was administered, this medicine was used as a last resort. For example, one care plan stated, "Staff are to use distraction methods when I'm very distressed, putting on my classical music and offering me a drink or snack."

Medicines were given as prescribed. We observed a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. Systems were in place to ensure that all medicines had been ordered, stored securely, administered safely and audited. Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Staff had an understanding of safeguarding and knew how to report any concerns. Records showed and staff confirmed they had completed safeguarding adults training. They were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. They told us they would report any concerns to the registered manager. Staff members' comments included, "I'd go to my manager first," "I'd report any concerns to the senior on

duty," "If I had any concerns I'd report it to the manager straight away," and, "I'd tell the nurse and they'd report it to safeguarding."

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Good

Is the service effective?

Our findings

Staff were positive about the opportunities for training to understand people's care and support needs. They told us they were kept up to date with training and that training was appropriate. Staff comments included, "We get plenty of training," "We have training every three months," "I've done most of the training," "Training is hard, there's a high pass rate needed on e learning," and, "There's loads of training."

Staff told us when they began working at the service they had completed an induction programme and had an opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. They said initial training consisted of a mixture of face to face and practical training. One staff member told us, "I had an induction and did essential training when I started."

The staff training records showed and staff told us they had received other training to meet peoples' needs and training in safe working practices. There was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that helped them to understand people's needs and this included a range of courses such as, end of life care, nutrition awareness, mental capacity, nutrition awareness, distressed behaviour, dementia care, vision awareness, effective communication, catheter care, record keeping, diabetes and person centred care. Several staff had obtained or were studying for a diploma in health and social care previously known as National Vocational Qualifications (NVQ).

Staff told us and their training files showed they received regular supervision from the management team, to discuss their work performance and training needs. Staff members' comments included, "The manager does my supervision," "I do supervisions with six support workers," "We have supervision every three months," "We talked about my training and development at my supervision." Staff told us they were well supported to carry out their caring role. All staff said they had regular supervision to discuss the running of the service and their training needs. They said they could also approach the registered manager at any time to discuss any issues. They also said they received an annual appraisal with a six month meeting to review their progress and work performance.

Staff told us communication was effective. Staff members' comments included, "Communication is very good," "We work as team," and, "Communication is good amongst the staff." We were told a handover session took place, to discuss people's needs when staff changed duty, at the beginning and end of each shift. A formal verbal exchange of information took place about all people to ensure staff were aware of the current state of health and well-being of each person. Staff told us the diary and communication book also provided them with information.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

Records contained information about people's mental health and the correct 'best interest' decision making process, as required by the Mental Capacity Act 2005. Best interest decision making is required to make sure people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes. Peoples' care records showed when 'best interest' decisions may need to be made. For example, one person's care plan included, "[Name] will need assistance from staff for their day to day care and help from staff in making decisions regarding dressing, personal hygiene and offering a balanced diet." People were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'. Examples from care plans included, "For complex decisions [Name]'s wife with the support from the care team and medical team will help," and, "[Name] can make day to day decisions but more complex decisions will be made with the support of [Name]'s family."

CQC monitors the operation of the Mental Capacity Act 2005(MCA). This is to make sure that people are looked after in a way that does not inappropriately restrict their freedom and they are involved in making their own decisions, wherever possible. Staff were aware of and had received training in the MCA and the related Deprivation of Liberty Safeguards (DoLS). They had a good understanding of the MCA and best interest decision making, when people were unable to make decisions themselves. The registered manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. The registered manager told us 21 applications had been authorised, three applications were being processed, 17 people did not require them and other applications were in the process of being completed for people.

Staff asked people for permission before delivering any support. They said they would respect the person's right to refuse care. Staff said if a person did refuse they would offer alternatives or leave the person and try again later. For example, if a person refused to receive assistance with personal care.

Relatives told us they were kept informed by the staff about their family member's health and the care they received. Relatives' comments included, "Staff get in touch if anything goes wrong," "I'm informed of any incidents," "Staff seem to know what they are doing," "Staff keep me up to date about [Name]," and, "I'm kept informed about [Name]'s health and if there's any change in their condition."

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals such as, General Practitioners (GPs), psychiatrists, a speech and language team (SALT) and psychiatrists. Records were kept of visits. Care plans reflected the advice and guidance provided by external professionals.

We spoke with the two visiting health care professionals during the inspection. They told us people were referred straight away if there were any concerns about their health and staff followed their advice and guidance. They also said staff were caring and communication was good. One visiting professional commented, "They're good at contacting us." We were told two local General Practitioner surgeries, where people were patients, held weekly clinics at the home to review people's health needs and to make sure they were treated promptly. It was also to help prevent people's unnecessary admission to hospital. A consultant psychiatrist also held a three monthly clinic at the home to review their patients' progress, care and medicines.

Systems were in place to ensure people received drinks and varied meals at regular times. We looked around the kitchen and saw it was well stocked with fresh, frozen, home baked and tinned produce. We spoke with the chef who was aware of people's different nutritional needs and special diets were catered for.

They explained how people who needed to increase weight and to be strengthened would be offered a fortified diet and how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. The chef told us they received information from nursing staff when people required a specialised diet. Written information was available in the kitchen to inform any cook of the dietary preferences and specialised diets for people when the regular cook was not available. For example, diabetic, vegetarian and soft or pureed diets.

Meals were well presented and people told us they had a choice at meal times. Peoples' comments included, "The food is okay. We don't often get Italian or Indian food but the chef has occasionally done a curry and we've had Chinese sweet and sour too," "There's a full range at breakfast and cooked breakfast is available," "The food is basic and bland sometimes," and, "Lunch is usually lovely but tea can leave a lot to be desired at times."

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Care plans were in place that recorded people's food likes and dislikes and any support required to help them eat. For example, information in two care plans included, "[Name] continues to enjoy a good diet but will sometimes need assistance from one care worker if they are sleepy," and, "[Name] likes to have small portions when having their meals."

There was a programme of decoration around the home. The environment was mostly well-maintained. However, we considered improvements were required on the top floor. The environment was showing signs of wear and tear as paintwork was scuffed and chipped to some doorways and walls on the corridor and some bedrooms. We were told that this would be addressed. We observed an indoor smoking room had been created on the lower ground floor for the comfort of people who lived at the home and smoked. This meant they did not have to be outside in bad weather. However, we considered improved ventilation was required in the smoking room as the smell permeated out of the room when people opened the door. We were told this was being addressed as the smoking room had just been created and a mechanical ventilation unit had been identified and had been ordered.

Good

Is the service caring?

Our findings

People who could comment were positive about the care and support provided. Their comments included, "Staff are really nice, they always do that bit extra," "Staff usually listen to me." "The home is as good as it gets "I like it here," "The staff and people are lovely," and, "I'm happy with the care." Relatives' comments included, "Staff are kind and caring and definitely patient," "Staff cope well," "The staff are very good," "The staff are fine, no problems," and, "The staff are very approachable." Relatives' comments from the 2015 provider survey included, "I generally find the staff very pleasant and helpful," and, "The majority of staff on duty are excellent carers."

During the inspection there was a relaxed and pleasant atmosphere in the home. It was noticeable since the last inspection the ground floor lounge which accommodated people with dementia was much more tranquil and calm. It was a sunny and bright room and people looked comfortable. Throughout the home staff interacted well with people. They were warm, kind, caring and respectful with people and people appeared comfortable with them. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance with a gentle touch on the arm. They explained what they were doing as they assisted people and they met their needs in a sensitive and compassionate manner. For example, when they offered assistance to people as they moved to the dining table for lunch or when a staff member offered a person a choice of drink at coffee time. We observed a staff member respond to a person who'd called for attention saying, "Hello, what can I do for you."

Staff were patient in their interactions and took time to observe people's verbal and non-verbal communication. Staff asked people's permission before carrying out any tasks. For example, we heard a staff member ask people if it was alright to turn the television off. Peoples' care plans contained detail of how staff were to support people. For example, one care plan stated, "Staff will explain to [Name] slowly and in a simple way as they help [Name] with their day to day care," and, "[Name] speaks quietly."

People's privacy was respected. Staff treated people with dignity and respect. We saw staff observed and offered any prompts and words of encouragement to people at meal times to provide assistance. Staff knocked on people's doors before entering their rooms. A person commented, "Staff always knock if the door is closed." People looked clean and well presented. Most people sat in communal areas but some preferred to stay in their own room.

We saw people who lived with dementia were encouraged to make a choice and be involved in decision making. For example, with regard to meals, drinks and other activities of daily living. One person's care plan recorded, "Staff will offer a choice of meals to [Name] and [Name] will tell them if they want tea or coffee." Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed

facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. One staff member commented, "I can tell from [Name]'s facial expression if they are in pain or discomfort. It's so important to recognise the signs." Peoples' care records included detail to inform staff how people communicated if they were in pain. For example, one care plan stated, "[Name] will tell staff if they feel unwell or has pain."

Information was available for people to keep them informed and to help them make choices. Each floor of the home and the entrance hall advertised the daily menus and activities available. We observed the notice board on the lower ground floor was not accessible to people who used a wheelchair as it was positioned too high for them to be able to read. One person commented, "I just ask and staff will tell me."

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision themselves. For example, an emergency health care plan was in place for a person. The care plan detailed the "do not attempt resuscitation" (DNAR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met. A care plan for a person who was not receiving end of life care stated, "[Name's] family, staff and General Practitioner will discuss and put in place an end of life care plan. This care plan will make sure [Name] is comfortable, clean and their dignity and privacy will be maintained at all times," and, "Any medicines required for pain relief will be prescribed and administered to make sure [Name] remains comfortable."

We were told the service used advocates as required but most people had relatives. Advocates can represent the views for people who are not able to express their wishes. Information was displayed that advertised what advocacy was and how the service could be accessed.

We observed the lunch time meal on the three floors of the home. The atmosphere was busy but measures were in place such as turning the television off to create a relaxed atmosphere so people were not distracted from eating. Staff were seated with people who required support and interacted with them individually. Staff provided full assistance or prompts to people to encourage them to eat, and they did this in a quiet, gentle way and explained to people what they were getting to eat with each spoonful. Staff talked to people as they helped them and as lunch was served. People sat at tables set with tablecloths and napkins, however napkins and condiments were not available for people on the top floor. Specialist equipment such as cutlery and plate guards were available to help people. People sat at tables set for three or four. Staff addressed people by their preferred name or title. Staff did not assume people's preferences and offered people a choice of food verbally or showed two plates of food that contained the two options. Staff members asked people if they wanted gravy and sauce as they were served.

Good

Is the service responsive?

Our findings

At the last inspection we had concerns that records did not accurately reflect people's care and support needs for staff to provide the correct care and support to people in the way the person wanted and needed.

We saw that improvements had been made to ensure that records accurately reflected peoples' care and support needs. However, we had concerns about the location of care plans for people as they were kept on the lower ground floor and staff from other floors may not have easy access to them. A discussion took place with the provider and registered manager at inspection to address this and arrangements were made to ensure staff had access to peoples' care and support plans on each floor. Peoples' care records for each floor were to be moved to more accessible, but secure areas of the home so staff could read them and familiarise themselves with peoples' care and support requirements.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, activities of daily living, communication and moving and assisting needs. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. For example, with regard to nutrition, communication, pressure area care, mobility and falls and personal hygiene. Evaluations were more detailed and included information about peoples' progress and well-being.

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in peoples' needs. For example, the speech and language therapist was asked for advice with regard to swallowing difficulties and communication. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people, when staff turned a person in bed, where it was identified a person was at risk of developing pressure areas, when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service. Care plans were more detailed and provided information for staff about how people liked to be supported. One staff member told us, "The nurses are responsible for the people with nursing needs and the senior support workers write other peoples' care plans." Two care plans for personal hygiene for example, stated, "[Name] will choose their own clothes but will need assistance from one care worker," and, "[Name] requires assistance from one member of staff for their personal care with prompts when getting dressed and washed to help them remain independent."

People's care records were up to date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. For example, "I prefer a quiet celebration for my birthday," "[Name] likes to watch sport on television," "[Name] has a glass of 'Irish Cream' before bed," and, "[Name] enjoys activities especially jigsaws." A relative commented, "Staff love [Name] they know [Name] likes music and they will take them downstairs if a singer comes in."

An activities organiser was available and when they were not on duty staff carried out activities with people. A programme of activities was advertised and this included, board games, pamper sessions, movie afternoons, baking, doll therapy, music therapy and crafts. However, we did not see activities taking place on the day of inspection as staff were busy. We observed the activities organiser was busy putting up bunting for a celebration for the Queen's forthcoming 90th birthday. We were told there were plans to create a vegetable patch and erect a greenhouse as some people enjoyed gardening. Peoples' comments about activities included, "I had my nails done yesterday," "I do painting and drawing and I like planting," "People go out on a trip on Thursdays," "Staff took me by bus into town," "We go to the coast and have fish and chips," "I've been out on the minibus for trips," "I feel cut off from society as I have no letters and no newspapers," (This was further discussed as the person said they hadn't told any member of staff) , "I play dominoes sometimes," and, "I do jigsaws." Entertainment and concerts also took place. A member of staff commented, "We're going to get pat-a-dog' to visit the home. Transport was available and people had the opportunity to go out on trips to the coast and other places of interest. We were aware the results of a provider survey from 2015 had asked for improvements to activities and we were told some action had been taken.

The registered manager told us of links with the community whereby local college and school children visited. The students were volunteers and carried out activities and spent time talking individually with people if they wanted to be involved.

More regular meetings were held with people who used the service and their relatives. The registered manager told us meetings provided feedback from people about the running of the home. We saw meetings were held every two months in order to improve communication between relatives and staff at the home. This frequency had been put in place as a result of feedback from the provider survey results from 2015. We discussed the possible formation of a separate resident meeting with people who used the service, depending upon people's interest. This could further improve consultation with people to gather their views about the running of the home and areas of importance such as menus and activities. The registered manager said this would be explored to check people's interest.

People said they knew how to complain. A person commented, "I would just tell someone." Relatives' comments' included, "I'd go to the seniors if I had any concerns or support workers or to the manager if really serious." The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained and we saw one had been received and had been investigated and resolved.

Good

Is the service well-led?

Our findings

A registered manager was in place who registered with the Care Quality Commission (CQC) in September 2015. The registered provider had been pro-active in submitting statutory notifications to the CQC, such as safeguarding notifications, applications for DoLS and serious injuries.

We found that the areas of noncompliance identified at the last inspection had been rectified and the registered manager had made improvements to the service to benefit people who used the service and staff. Systems were in place for managing and mitigating risk. Care records accurately reflected peoples' support needs and contained the information staff needed to safely care for people.

The atmosphere in the service was friendly and relaxed. Staff said they felt well-supported. They said they could approach the management team at any time to discuss any issues. Staff members' comments included, "The manager is lovely," "The manager is very, very approachable," "You can talk to the manager about anything," and, "Staff are a lot happier."

Records showed audits were carried out regularly. They showed action that had been taken as a result of previous audits where deficits were identified and the follow up action that had been taken. Weekly checks included for the nurse call system, fire checks, medicines stock, care documentation and financial checks. Monthly audits included checks on staff training, medicines management, accidents and incidents, infection control, nutrition, skin integrity, falls and mobility. Checks were carried out on personnel files and finances. The registered manager told us monthly visits were carried out by the provider or compliance manager to speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans and staff files. These were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

Staff told us and we saw staff meeting minutes to show staff meetings took place regularly and these included nurses and senior support staff meetings. Staff meetings kept staff updated with any changes in the service and to discuss any issues. Staff members told us meeting minutes were made available for staff who were unable to attend meetings. Staff members' comments included, "Flash meetings will be called if something needs discussing and the manager will have a quick meeting with staff after handover," and, "Staff meetings take place." Meeting minutes from March 2016 showed areas discussed included, "infection control, feedback from the provider's recent compliance visit and staff performance."

The manager told us the registered provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out six monthly to people who used the service and staff. Surveys had been completed by people who used the service in June 2015. We saw the results had been analysed and feedback was advertised in the home showing what action was to be taken as a result of the survey. For example, people had stated activities needed to improve. As a result a new activities person was in post, a list of activities available each day was advertised on the notice boards around the home which had been purchased to assist with communication. Also as a result of feedback to assist communication two monthly resident and relative meetings were to be

held.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured staffing levels were sufficient to provide safe and person centred care to people at all times.