Gainford Care Homes Limited

Lindisfarne House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

Lindisfarne House is registered to provide personal and nursing care to a maximum of 60 people. Care is provided to older people including people who live with dementia and a unit provides support to some younger people who have a physical dependency.

At the last inspection in April 2016 we had rated the service as 'Good'. At this inspection we found the service remained 'Good' and met each of the fundamental standards we inspected.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support. People told us they were safe. At our last inspection we had found the service in breach of Regulation 18, staffing. At this inspection we found improvements had been sustained and there were sufficient staff to provide individual care and support to people.

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. There were other opportunities for staff to receive training to meet people's care needs.

People were involved in decisions about their care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff were patient and kind as they supported people.

Records were regularly reviewed to reflect people's care and support requirements. People had access to health care professionals to make sure they received appropriate care and treatment. Staff supported people who required help to eat and drink and special diets were catered for.

Some activities and entertainment were available for people. We have made a recommendation to increase the variety of activities.

Complaints were taken seriously and records maintained of the action taken by the service in response to any form of dissatisfaction or concern.

A range of systems were in place to monitor and review the quality and effectiveness of the service. 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.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Improvements had been made to increase staffing levels so support staff were available to support people in a person centred way. People received their medicines in a safe way.

People were protected from abuse and avoidable harm as staff had received training with regard to safeguarding. Staff said they would be able to identify any instances of possible abuse and would report it if it occurred.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

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 12 April 2017 and was unannounced.

It was carried out by an inspector and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses a service for older people.

Before the inspection we reviewed information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care. We also contacted the local safeguarding teams and Healthwatch volunteer organisation.

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.

During the inspection we spoke with 26 people who lived at Lindisfarne House, ten relatives, the registered manager, the area manager, two registered nurses, ten support workers including two senior support workers, the activities organiser, one visiting health care professional and two members of catering staff. We looked around the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for six people, recruitment, training and induction records for four staff, five 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.

Good

Is the service safe?

Our findings

Due to their health conditions and complex needs not all people were able to share their views about the service they received. Other people told us they were safe and most staff attended to them promptly. Their comments included "I do feel very safe here, they (staff) look after us very well", "Of course I feel safe-I have had no problems at all", "I feel safe here, the staff are all very nice" and "I'm well looked after, it's okay here." One relative told us "[Name] is in a good place, we visit every week and they are well looked after."

At the previous inspection we had considered staffing levels were not sufficient to meet the needs of people who used the service. Immediate action was taken at the time of that inspection to increase staffing levels. At this inspection we considered there were sufficient staff to meet people's needs safely. However, we discussed with the registered manager the need to ensure staff deployment was kept under review at busy times of the day especially to the top floor as the registered nurse was not always available to assist with direct care. This was to ensure the needs of people were met in a timely way as a person had told us "The mornings are the worst time, I have to wait and I can't wait. Staff have a lot to do and everyone needs the bathroom."

We were told staffing levels were determined by the number of people using the service and their needs. Results from a recent provider survey showed the people who had been asked thought sufficient staff were on duty. There were 55 people who were living at the home. Staffing rosters and observations showed during the day on the top floor 14 people were supported by one nurse and three support workers. On the middle floor 24 people were supported by five support workers and a registered nurse. On the ground floor 17 people were supported by three support workers and a registered nurse who also covered the top floor. Overnight staffing levels included one nurse and six support workers including one senior support worker.

Staff told us they had completed training in how to identify and report any concerns that a person was at risk of abuse. Where staff had concerns about an individual being at risk of harm they told us they would know how to take the appropriate action to protect the individual and other people who could be at risk. One staff member told us "I'd report any concerns straight away to the senior." Another member of staff said "I'd go to the manager or senior and fill in a body map if needed."

Risks to people's safety had been identified and actions taken to reduce or manage hazards. Risk assessments were recorded in people's care records to guide staff on the actions to take to protect individuals from harm. For example from falls or choking. Where an accident or incident did take place these were reviewed by the registered manager or another senior staff member to ensure that any learning was carried forward. A member of staff told us "Reflective practice happens at staff meetings to see if we could have done anything differently or to make any improvements." There were personal evacuation plans for each person in the event of an emergency.

Arrangements were in place for the on-going maintenance of the building and a maintenance person was employed. The home staff carried out monthly health and safety checks. Routine safety checks and repairs

were carried out such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances.

We checked the management of medicines. All medicines were appropriately stored and secured. Medicines records were accurate and supported the safe administration of medicines. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed. Care plans were in place that detailed the guidance required for staff to administer medicines in the way the person wanted.

Staff personnel files showed that a robust recruitment system was in place. This helped to ensure only suitable people were employed to care for vulnerable adults. Staff confirmed that checks had been carried out before they began to work with people.

Good

Is the service effective?

Our findings

People were supported by skilled, knowledgeable and suitably supported staff. People we spoke with and their relatives praised the staff team. Staff told us they were trained to carry out their role. Their comments included, "We receive a lot of support", "Training is very good", "We do on line and face to face training", "We're going to have continence trainers", "I'm doing a National Vocational Qualification (NVQ) (now known as diploma in health and social care) at level two and would like to do level 3 as well" and "I've done training about end of life care."

Records showed that staff received induction, supervision and appraisal. This allowed new staff to be supported into their role, as well as for existing staff to continually develop their skills. Staff we spoke with told us they could access day to day as well as formal supervision and advice and were encouraged to maintain and develop their skills.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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. We found as a result, that 30 people were currently subject to such restrictions.

Records contained information about people's mental health and the correct 'best interest' decision making process, as required by the MCA. People were involved in developing their care and support plan. 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'. Staff were aware of the need to gain people's consent and explained they would respect people's wishes where they declined support.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. For example the GP, dietician and speech and language therapist. People also had access to dental treatment, chiropody and optical services. Relatives told us they were kept informed about their family member's health and the care they received. One relative commented, "[Name] is well looked after, staff will let me know how [Name] is." Another relative told us, "Staff know [Name]'s personality and changes in mood, they contact us immediately if there is anything

untoward."

Staff supported people to ensure they received sufficient nutritious food. One relative commented "They (staff) make sure [Name] gets enough food and fluids." People were complimentary about the food. Their comments included "The food is fantastic", "Breakfast is okay but meals aren't very adventurous", "The food is good" and "There is plenty of food." People's food and fluid intake was monitored and people at risk of poor nutrition were supported to maintain their nutritional needs.

Good

Is the service caring?

Our findings

During the inspection there was a happy, relaxed and pleasant atmosphere in the home. People moved around the units as they wanted. Care was provided in a flexible way to meet people's individual preferences. For instance, people had the opportunity to have a lie-in. People who could speak with us were positive about the care and support provided by staff. Their comments included, "It's nice and warm here, I'm well looked after", "I am happy here, they (staff) are very good to me", "The care I'm receiving here is fantastic, they are fantastic staff." Other peoples' comments included, "The staff are wonderful, I love their kindness", "It's lovely in here, but I would love to go home", "The staff are lovely, nothing is a bother." Relatives comments included, "The staff are first class, they do a difficult job very well" and "Staff are lovely, they couldn't be better with [Name]."

Staff interacted well with people, sitting with them and spending time with them when they had the opportunity. They understood their role in providing people with effective, caring and compassionate care and support. They were knowledgeable about people's individual needs and personalities. People told us they were encouraged to make choices about their day to day lives.

Staff took time to listen and observe people's verbal and non-verbal communication. Not all of the people were able to fully express their views verbally. Guidance was available in people's care plans which documented how people communicated. Staff told us they 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 "Some people may communicate with their eyes."

Staff treated people with dignity and respect. We observed good practice throughout the inspection. Staff members always knocked before entering people's rooms and were discreet when speaking to people about their care and treatment. Records were held securely and staff were aware of the need to handle information confidentially.

We observed the lunch time meal in the different dining rooms of the home. The atmosphere was calm and staff tried to ensure people received a pleasurable dining experience. 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. Staff spoke with people in a quiet, gentle way and explained to people what they were getting to eat. 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. Portion size was also varied according to people's needs.

The service used advocates as required and people were supported by Independent Mental Health Care Advocates (IMHCA) because they lacked the mental capacity to make decisions with regard to their well-being. 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.

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 for themselves. People's care plans detailed the arrangements that were in place. The nursing staff told us that they worked closely with the community palliative care team to support a person when they were reaching the end of their life and a palliative care register was in place. Support staff received training about end of life care.

Good

Is the service responsive?

Our findings

People confirmed they had a choice about getting involved in activities. However, some people and relatives told us they would like more activities and outings. People's comments included, "I was baking cakes recently and I've been to the park", "It's alright here, I play snooker sometimes, however sometimes I have to play by myself as staff are busy", "I've been out to Beamish Museum and Kirkley Hall farm", "I listen to my talking books", "There isn't much entertainment, I would love to listen to piano music", "It's boring, but on the whole it's alright" and "There's nothing going on here I just watch television."

We observed around the home staff were busy in the morning and did not have time to spend with people except when they provided care. By the afternoon, staff said and we observed, they had more time to spend with people. The results of a recent provider survey with people and relatives showed more activities were wanted. We discussed activities provision with the registered manager and area manager who told us it was being addressed. They told us the activity co-ordinator worked 11 hours per week although the hours for activities had been increased from 35 hours to 50 hours. Additional staff to assist with activities provision were being recruited. The area manager also told us they were looking at encouraging more community involvement by fostering links with the local community such as schools and church groups.

We recommend that people are consulted to arrange a programme of activities that can take place regularly on an individual and group basis. This includes activities that can engage and stimulate people who live with more severe dementia.

Monthly meetings were held with people who used the service and their relatives. Meetings minutes provided feedback from people about the running of the home. Recent meeting minutes showed a new minibus had been purchased for outings. Activities had been discussed and suggestions had been made to progress activities provision.

Before people used the service an initial assessment was completed to ensure the service could meet the person's needs. Care plans were developed that outlined how these needs were to be met. They were up to date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. 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 personalised service. One relative told us, "[Name] is getting lots of good consistent care here, the staff are the same and this is good."

People's care records were kept under review. Monthly evaluations were undertaken by staff and care plans were updated following any change in a person's needs. Formal reviews of people's care planning took place. Family members told us they were invited to any meetings to discuss their relative's care. One relative told us "We are very involved in [Name]'s care and care plans." Another relative commented "We have regular meetings with the manager."

People using the service and their relatives told us knew how to complain to if they needed to and expressed confidence that issues would be resolved. Most said they would speak to the registered manager or a senior member of staff if they had any concerns. A copy of the complaints procedure was clearly available in the hallway and information was given to each person about how they could complain. A record of complaints was maintained.

Good

Is the service well-led?

Our findings

A registered manager was in place who had registered with the Care Quality Commission in 2016. 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.

The provider had displayed the Care Quality Commission's (CQC) rating of the service, including on their website, as required, following the publication of the last inspection report.

The registered manager assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The registered manager and provider's representative, who joined the inspection for the feedback, were able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

The registered manager was enthusiastic and had introduced ideas to promote the well-being of people who used the service. Staff and people we spoke with were positive about their management and had respect for them. They told us the service was well led. They said they could speak to the registered manager, or would speak to a member of staff if they had any issues or concerns. Staff said the registered manager was supportive and accessible to them. People's comments included, "[Name] manager is good, they're approachable", "[Name], the manager, goes out of their way to ensure we are all well. They'll move heaven and earth and always takes time to talk" and "Everyone here is very friendly and the registered manager is very approachable."

Staff meetings were held to keep staff informed of changes within the service and to provide them with the opportunity to raise and discuss concerns. Staff comments included, "Staff meetings happen every few months" and "The proprietor listens to what we say. We requested carpet and we got it straight away."

The registered manager was supported by a management team in the home that was experienced, knowledgeable and familiar with the needs of the people the service supported. They told us they were well supported by the provider's management team based at head office. They had regular contact with head office, ensuring there was on-going communication about the running of the home. Regular meetings were held where the management were appraised of and discussed the operation and development of the home.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who lived in the home. The audits consisted of a wide range of monthly, quarterly and annual checks. They included the environment, medicines, health and safety, accidents and incidents, complaints, personnel documentation and care documentation. Audits identified actions that needed to be taken. Audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. A weekly risk monitoring report that included areas of care such as safeguarding,

complaints, pressure area care, falls and serious changes in a person's health status was completed by the registered manager and submitted to head office for analysis.