Gainford Care Homes Limited

Lindisfarne Birtley

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
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

Lindisfarne Birtley provides accommodation for up to 66 people who need support with their personal and health care. The home mainly provides support for older people many who are living with dementia. The home also provides support to some younger people with an acquired brain injury and/or mental health needs. The home is a large, purpose built property. Accommodation is arranged over three floors and there is a passenger lift to assist people to get to the upper and lower floor. The home has 66 single bedrooms all with an en suite facility. There were 62 people living at the home at the time of our inspection.

This was an unannounced inspection, carried out over two days on 30 October and 5 November 2014. There was a registered manager in place. 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.”

We last inspected Lindisfarne Birtley in June 2014. At that inspection we found the service was in breach of its legal

Summary of findings

requirement with regard to regulation 17 with regard to respecting and involving people. This was because people who lived with dementia were not provided with care that met their individual needs.

At this inspection we saw some improvements had been made, however we found further work was needed to improve the care and experiences of people who lived with dementia. We saw people who lived with dementia enjoyed a better dining experience although this could still be improved. We found people who lived with dementia were not encouraged to remain involved with their surroundings and to make choices.

We found there were not always enough staff on duty to provide individual care and support to people and to keep them safe as staffing levels were not maintained.

We saw 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. We found, however there were limited opportunities for staff to receive training to meet all of their care needs. For example, only the manager had an understanding and knowledge of The Deprivation of Liberty safeguards and best interest decision making when people lacked mental capacity.

We saw detailed care plans were not in place to help staff manage and provide consistent care to people who may display distressed behaviour. We saw some people records showed, there was a use of " when required" medicines, to manage their behaviours.

We saw staff did not interact and talk with people when they had the opportunity. There was an emphasis on supervision and task centred care.

Staff did not always provide care that was responsive to people's needs. Care records we looked at were not all up to date with evidence of regular evaluation and review to keep people safe and to ensure staff were aware of their current individual care and support needs.

We saw records were not in place for all people to make staff aware of the person's individual preferences, likes and dislikes. This meant staff were not reminded the person was a unique individual with a history. Information was also not available for all people with regard to their end of life care wishes.

We spoke to the activities organiser, who had lots of ideas to help keep people stimulated. We saw they engaged well with people, however when they were not available, other staff did not provide activities for people to remain stimulated. Relatives we spoke with did say more activities and outings needed to be provided for people. They spoke of two outings that had taken place in the summer but said more stimulation was needed in the service. One person said; "The days can be very long."

We found there was not an ethos from management to encourage staff to ensure people maintained some control in their lives. There was little evidence that people were helped to make choices and to be involved in every day decision making.

The audits used to assess the quality of the service provided were not effective as they had not identified the issues that we found during the inspection.

The necessary checks were carried out to ensure the building was safe and fit for purpose.

We found five breaches of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010 in relation to staffing levels, respect and involvement, staff training, record keeping and monitoring the quality of service.

You can see what action we told the 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?

Not all aspects of the service were safe. Although people told us they felt safe we found systems were not all in place to ensure their safety and well- being at all times. We found not all safeguarding incidents were dealt with appropriately.

People were sometimes at risk because sufficient staff were not always on duty to provide supervision and care to each person. Staff did not have guidelines to safely manage and provide consistent care to people who displayed distressed behaviour. We had concerns with regard to the use of "when required" medicines.

We saw some other checks to protect people were in place. Staff were appropriately vetted. Regular checks took place to make sure the building and equipment used to transport people were safe and fit for purpose.

Requires Improvement

Is the service effective?

Not all aspects of the service were effective. We saw there were limited opportunities for staff to receive specialist training to give them more knowledge and insight into people's care and support needs.

The deprivation of liberty safeguards were understood by the manager, however other staff were not aware of the safeguards. People's rights were not always protected because there was little evidence of best interest decision making, when decisions were made on behalf of people.

We saw the environment was not designed and adapted to help people who lived with dementia to be aware of their surroundings. People who lived with dementia did not always receive care that took account of their wishes.

Requires Improvement

Is the service caring?

Not all aspects of the service were caring. We saw there was an emphasis on task centred care with people as staff did not have time to spend talking with people or engaging with them. We observed staff sat on corridors outside the lounge areas where people were sitting, to supervise them, rather than sitting amongst people.

People's dignity was not always promoted, especially in relation to meal times. We found people who lived with dementia were not helped to make choices and to be involved in daily decision making.

Relatives we spoke with were on the whole complimentary about the care and support provided to people

Requires Improvement

Summary of findings

Is the service responsive?

The service was not always responsive to people's needs. Written information was not available for all people to make staff aware of the person's individual preferences, likes and dislikes, reminding staff the person was a unique individual with a history and a future.

People did not always receive support in the way they needed because staff did not have detailed guidance about how to deliver people's care. Care plans were not all in place, or up to date to meet people's care and support requirements.

People had limited opportunities for activities when the activities organiser was not available. People and relatives spoken with did say more activities and outings needed to be provided.

Requires Improvement

Is the service well-led?

Not all aspects of the service were well-led. The registered manager did not encourage an ethos of involvement amongst staff and people who used the service. People were not encouraged to be involved in daily decision making and to maintain some awareness and control in their lives.

The systems used to assess the quality of the service had not identified the issues that we found during the inspection. Therefore the quality assurance processes were not effective as they had not ensured that people received safe care that met their needs.

Requires Improvement

Lindisfarne Birtley

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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 over two days on 30 October and 5 November 2014 and was unannounced. The inspection team consisted of two inspectors and a specialist nursing advisor. The specialist advisor helped us to gather evidence about the quality of nursing care provided.

We undertook general observations in communal areas and during mealtimes. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We did not request a Provider Information Return (PIR) before we undertook the inspection, due to the late scheduling of the inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information we held about the home. We also contacted commissioners from the local authority and clinical commissioning group who contracted people's health and social care. The local authority commissioners told us the service was in contractual "default", as they were not meeting their contractual obligations with regard to care planning, staff training and quality assurance. We spoke with the local safeguarding team. We received other information of concern with regard to staffing levels.

During the inspection we spoke with 11 people who lived at Lindisfarne Birtley, six relatives, two nurses, nine care workers, the activities coordinator, two catering staff and the registered manager. We observed care and support in communal areas and looked in the kitchen and four people's bedrooms. We reviewed a range of records about people's care and how the home was managed. We pathway tracked seven people and this included four people whom we were told displayed distressed behaviour. This meant we spoke with staff, looked at people's care records and medicines records, to see how the person was supported. We looked at care plans for 12 people, the 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 their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the registered manager completed.

Requires Improvement

Is the service safe?

Our findings

Some people who could talk with us, said they felt safe and one person commented; " I feel safe living here." A relative said; "The few staff try their best, but cannot keep up, and it is only a matter of time before someone is hurt falling." Another relative raised concerns about the lack of stimulation and opportunities for their relative, on the younger person's unit, to go out either individually or in a small group. They commented; "Most staff are very hardworking and they try to give residents time-but there are not enough staff for the amount of residents." Another person commented; " The staff come when they can, but they are kept busy."

We received some concerns about staffing levels during and immediately after the inspection with regard to the numbers of staff on duty. Staff rosters and evidence at the time of inspection showed some staff went off duty at 2pm, and they were not replaced so staff numbers reduced when they were not replaced. We observed some staff members moved to work on different floors during the day. This meant when a support worker moved from one floor to another, it reduced the numbers of support workers left to provide care and support to people on that floor. On the nursing and younger person's unit we saw some people displayed distressed behaviour which staff did not always have time to attend to in a timely way as they were assisting other people.

One activities person was employed to cover the whole home. They told us they were involved with care duties if assistance was required and they also helped people at breakfast each day. The registered manager told us sometimes there were no staff available to cover when staff were absent from work due to sickness, holidays or training, so staffing levels would fall on these occasions when absent staff were not able to be replaced. They told us the registered provider was establishing a bank of spare staff who would be called upon when required. The registered manager also told us new staff were in the process of being recruited. We looked at further staff rosters after the inspection, when new staff had begun work, however they showed there was still not consistent and sufficient staffing maintained over seven days of the week. Therefore although people told us they felt safe we found enough staff were not always on duty to ensure the safety and well-being of all people who used the service.

We saw people's care and support needs were not always taken into account when deciding upon staffing levels which had not increased since the last inspection, despite the increased occupancy and the higher dependency of people who used the service. Records also showed that a person who had no understanding of danger, and who was subject to Deprivation of Liberty Safeguards (DoLS) had left the building without the knowledge or agreement of staff. Other records showed some people presented with distressed behaviour that required more intensive staff support to help reassure them and keep people safe. Therefore people's needs were not met when sufficient staff were not on duty. We were therefore concerned there were not enough staff on each duty each day to ensure that all people's needs were met in a safe and timely way.

This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Information from the local authority safeguarding team showed us six potential safeguarding incidents had been raised in 2014, and three had proceeded to safeguarding investigation. One person's daily communication records also showed a person had left the building twice without staff agreement. When we looked at the home's safeguarding log, we saw these incidents had not been recorded, the safeguarding authority also confirmed these incidents had not been reported.

We spoke with staff who confirmed they had not recognised them as safeguarding incidents that required reporting. We spoke with the local authority commissioners, who had already identified, during their monitoring visits, that staff required safeguarding training to ensure they were all aware of how to recognise signs of potential abuse, and to make them familiar with the alerter's role and when an incident was a potential safeguarding and needed to be reported. At the time of inspection the registered manager told us all staff were to receive local authority safeguarding training, to assist staff in recognising signs of abuse and to report any concerns to the registered manager. This was confirmed by the local authority safeguarding department and we saw it was taking place, at the service on our visit on 5 November 2014.

We checked the management of medicines. We observed a medicines round on the ground floor and saw photographs were attached to people's medicines administration records (MARS) so staff were able to identify the person

Requires Improvement

Is the service safe?

before they administered their medicines. We saw the support worker remained with each person to ensure they had swallowed their medicines. The MAR was checked and all medicines were signed for after administrations. We noted however that not all MAR were coded to explain the reason why some medicines had not been administered.

We saw there was no written guidance for the use of "when required" medicines, and when these should be administered to people who showed signs of agitation and distress. When required medicines are those given only when needed; such as for pain relief.

We saw all medicines were appropriately stored and secured within the medicines trolley or treatment room. However, we found concerns with certain aspects of medicines management. We saw three people received covert medication. Covert medicine refers to medicine which is hidden in food or drink. No documentation was available to show why this was required, other than the MAR record referred to the need and that it had been authorised by the GP. There was no evidence to show if all other ways had been exhausted before the decision was reached and there was no evidence that the decision was reviewed. We saw the decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had not taken place with the relevant people. "A best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests."

We recommend the provider considers the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes. We considered improvements were required for the management of medicines to record the reason why medicines might not be administered. Also for written guidance to be available for the use of "when required" medicines.

Records showed that risk assessments such as for tissue viability, nutrition, falls and oral health were mostly in place but they were not regularly reviewed and evaluated. A mobility assessment for a person who had sustained a fractured hip had not been evaluated since June 2014.

We were told by the registered manager and other staff there was enough specialist equipment to help with the moving and handling of people safely. However, we saw people who needed help to be moved with a hoist did not have their own sling for use with the hoist, to help keep people safe from the spread of infection. Staff told us if they thought particular people were at risk of infection they would be provided with their own sling.

We looked at records to check maintenance contracts, the servicing of equipment contracts, fire checks, gas and electrical installation certificates and other safety checks. We saw regular checks were carried out and contracts were in place to make sure the building and equipment such as the passenger lift, bath aids and hoists were safe and fit for purpose.

We spoke with members of staff and looked at four personnel files to make sure staff had been appropriately recruited. We saw the necessary checks had been carried out with the Disclosure and Barring Service (DBS) to ensure staff employed were suitable to work with vulnerable people. We saw they had been recruited correctly and the relevant references and a DBS result had been obtained before they were offered their job and began working with people.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with were positive about training opportunities. One staff member commented; "I love working here. NVQs are offered if you don't have it." Another staff member said; "I can ask for what I want." Another staff member said; " I haven't had dementia training but did National Vocational Qualification level 3, moving and handling and other training." And; "Can put ideas to the manager for training." One person said; "I got all my mandatory training as soon as I started." Staff we spoke with also said they received regular supervision from the registered manager, to discuss their work performance and training needs. One person said; "I just had one two weeks ago." Another said; "(Name of), the manager, is supportive, she does 1:1's every three months and an annual appraisal."

The staff training record showed staff had received training with regard to nutrition, dementia awareness and distressed behaviour. Over 90% of staff had studied National Vocational Qualifications (NVQ), now known as National Diplomas in Health and Social Care at levels 2 and over 75% at level three.

We saw although staff had received some training with regard to people's needs there was a lack of evidence that it was transferred into practice, to ensure people received care that was individual to each person. For example, we observed there was little evidence of a person who lived with dementia being encouraged to remain engaged and stimulated and aware of their surroundings. We observed pictorial aids were not used to prompt people's understanding if they no longer recognised the written word. Care planning was also listed on the training matrix, as an available course, but we saw no staff had received this training. We saw specific training and updates in practice, had not been requested from people such as the behavioural team, or other health professionals who were involved in the person's care, when a referral had been made by the home because of a person's distressed behaviour. In addition, we looked at staff training records and saw there was no evidence of recent training for all staff to increase their skills and knowledge in other areas to give them more knowledge and insight into people's conditions, such as dementia in younger people, Parkinson's disease. The registered manager told us mandatory training was being updated for all staff.

Support workers told us they had not received training with regard to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards(DoLS.) The registered manager told us all staff required the training and she was waiting for training dates from the local authority. We checked with the local authority who told us bookings would be able to be made from January 2015.

We had concerns that all staff had not received recent training, including MCA and DoLS to ensure staff were aware of their legal responsibility when working with people who did not have mental capacity.

This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

CQC monitors the operation of the DoLS. DoLS are part of the Mental Capacity Act 2005 (MCA). These are safeguards put in place by the MCA to protect people from having their liberty restricted without lawful reason. We checked with the registered manager that DoLS were only used when it was considered to be in the person's best interests. The registered manager was aware of a recent court judgement that extended the scope of these safeguards. We found as a result, that a number of applications were being considered and four people were currently subject to such restrictions.

Records showed there appeared to be limited understanding of the best interest decision making process, as required by the MCA. 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. For example, a nurse had completed an assessment for one person and the description of the decision stated; "medication, personal hygiene needs and care plan." However, we saw no specific decision was recorded and no follow up documentation was available to show why the assessment was carried out.

We discussed with the registered manager, the locked door policy that was in place on the units for people who live with dementia. People were unable to go into their bedrooms, as doors were locked. Individual assessments, were not in place, to check if a person could manage a key and therefore go to their bedroom as they wanted. This meant people who lacked mental capacity had their freedom restricted as they were unable to access their room when they wanted.

Requires Improvement

Is the service effective?

We checked how the service met people's nutritional needs. People we spoke with said the food was alright and there was plenty to eat. One relative commented; "There are a lot of casseroles, mash and sponge and custard type of meals." On the younger person's unit a person commented; "The food is nice and you can get a drink whenever you want-tea, juice anything at all."

We looked around the kitchen and saw it was well stocked with fresh, frozen and tinned produce. We spoke with the chef who was aware of people's different nutritional needs and special diets were catered for. We saw people who required a pureed diet had it appropriately served in individual portions rather than all the ingredients being blended together.

We saw staff acted promptly to involve other health professionals such as the GP, speech and language therapist, dietician, behavioural nurse and psychiatrist when they required advice and support to help make sure people's health care needs were met. A staff member told us; "Other professionals are involved, not sure of their roles as nursing staff deal with it, but we do have a key working system for meetings." The registered manager told us a GP surgery was held at the service weekly so people's medical needs could be attended to promptly. A relative we spoke with said;" I'm kept up to date and informed of any changes to X's health."

We saw the provider had made some improvement to help people who lived with dementia to maintain some independence. For example, the handrails to the corridors were painted in a different colour to help them stand out for people to use.

We found however, not all of the premises were "enabling" to promote people's independence, and involvement. People were unable to identify different areas of the home. There was no appropriate signage, doors such as lavatories and bedrooms were not painted different colours or with signs for people to identify the room and to help maintain their independence. The Alzheimer's Society states; "Design changes, such as using contrasting colours around the home, are very useful in making items easier for people with dementia to identify."

We saw no pictorial aids or orientation aids, such as activity boards, calendars, clocks and newspapers, magazines, books to help remind people of the date and time. Not all communal areas and hallways had decorations and suitable pictures on the walls to stimulate people as they passed through the corridors and no pictures or other objects of interest were placed at a height visible to people who used a wheelchair. This meant people were not helped, by their environment, to remember and be mentally stimulated. The registered manager told us a programme of decoration was to start in six weeks and then this work would be done. The registered manager showed us examples of pictures and signage that were to be purchased to help make the environment more appropriate to help the involvement of people who lived with dementia, however they had not yet been ordered.

We recommend the provider considers the National Institute for Health and Care Excellence (NICE) states; "Health and social care managers should ensure that built environments are enabling and aid orientation."(NICE, Dementia-Supporting people who live with dementia and their carers in health and social care, November 2006:18)

Requires Improvement

Is the service caring?

Our findings

Relatives we spoke with on the older person's units were on the whole complimentary about the care and support provided to people. One relative commented; "All staff are friendly and helpful." Another commented; "X has settled well here." Another relative commented; "The staff are kind and caring." One person said; "It's not home, but the staff try to make you comfortable." Another person said; "Yes, the staff are kind, but they are kept busy." Another person who used the service said; "There isn't much to do, but there's plenty to eat." We observed staff were patient and caring when they did interact with people.

We observed staff working with people on the younger person's unit. We saw they spent time with a person when they were upset, they were warm and caring and reassured the person in a calm manner and listened and engaged pro-actively. At lunch time we observed staff engagement was minimal but people were eating independently and some chatted amongst themselves.

We spent time observing staff practices on the older person's units. We saw staff did not take the opportunity to talk to people and spend time listening to what they had to say. Although we saw staff treat people kindly they did not take the time to listen to the response of the person. We observed many staff only engaged and interacted with people when they were carrying out a task with a person. For example, when they offered people a drink, or when they helped people to mobilise and then for some people, we noted the conversation was only to give instructions. We saw people sat sleeping in lounges for much of the time. When staff were available, they sat in a corner of the room at a table completing records. At other times, a member of staff sat out on the corridor, to provide supervision to people in the lounge and people who remained in their bedrooms. We saw care was task centred rather than person centred. This meant support workers carried out tasks with people rather than attending to them at a time they may choose and spending time sitting interacting with them. Staff told us they were kept busy and did not have time to sit with people. They said, in an afternoon there maybe a little more time, as mornings were very busy. They said they needed to complete the charts to show what care they had carrying out with the person. We saw they removed their chair from the corridor whilst we were there but they then returned the chair to the corridor to sit down when we moved to another area of the home. We discussed this with the registered manager and advised them it was not very caring as staff were employed to provide supervision, care and interaction with people.

We observed those people who were more able to communicate verbally received a little more interaction from staff, as they engaged with staff for their attention. We noted one person liked to spend time in the manager's office. Some people were aware, and as they walked along the corridor we enjoyed a conversation about football with them, otherwise they were left to walk up and down without any engagement from staff except an acknowledgement.

We had concerns that some staff actions did not always respect people's dignity and independence. On the middle floor we saw people were assisted to the dining room at 11:30am and because lunch was late, they sat at the table and waited an hour, before the meal was ready to be served. People were not told why the meal was late and no apology for the delay was made.

We observed the lunch time meal in each of the three dining rooms**.** We saw certain aspects of the meal time experience had improved. We saw the atmosphere was calm and relaxed in dining rooms and a "protected" meal time for older people was in place, where ancillary staff members, as well as some relatives assisted people with their meal.

Tables were set with tablecloths and specialist cutlery and plate guards were available to help people, who were able, to maintain some independence as they ate their food. We saw people were not encouraged to make a choice or be involved in decision making. Menus were not available nor available in any other format, if people no longer understood the written word, to make them aware of the meals to be served. Staff members did not, for example, show two plates of food to help a person who lived with dementia choose what they wanted to eat. We saw in two dining rooms, tables were pulled together to accommodate either 12 to 18 people to sit side by side in wheelchairs, rather than at smaller tables, as they waited to be assisted to eat.

We discussed our findings with the registered manager and advised them although some improvements had taken place, individual care was still not being provided to people who lived with dementia. More needed to be done to

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Is the service caring?

promote their involvement and to take into account the wishes and feelings of the individual. The registered manager told us a dignity champion had been appointed from amongst staff members. The champion was to be responsible for raising staff awareness with regard to the rights and dignity of people who used the service, however our findings at inspection did not find that this had been implemented yet.

We considered that improvements were necessary to the promote the involvement of people who used the service.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service responsive?

Our findings

We spoke with staff about people's needs. One staff member said; "I work on all floors but I know everyone so it's fine." Also; "I'm not usually on this floor." And; "Communication is good, spend time on handovers." Another person said; "I've just started working on this floor, I've been on other floors until recently."

Some staff we spoke with knew the individual care and support needs of people, as they provided the day to day support, however their knowledge of people's needs, was not reflected and detailed in the care plans as they were not involved in contributing to them. Staff we spoke with said the nurses were responsible for writing the care plans. We spoke with the registered manager and the nurses to remind them of the knowledge of staff who were involved in the provision of direct care and support to people. Their knowledge would be important as they delivered the daily care and support to each person, in the way the person wanted.

We looked at twelve people's care records and saw some information was received about people's needs before they moved into the home. This information was transferred into care plans to help staff provide care and support to people. We raised concerns however, with regard to the inappropriate storage of some records that were kept on the floor in the residential lounge as this did not maintain and respect people's confidentiality.

We had concerns regarding the management of people's behaviour which could be challenging. We found care plans were either not in place, or they were vague for at least four of the people who may show agitation or distress. Care plans did not give staff detailed guidance with regard to supporting people who used the service and to ensure they were kept safe. Detailed behaviour management information was not in place to help staff support and reassure the person if they became agitated or distressed. Records and daily recordings showed there was a use of sedation medicine for at least three people. For example, we saw a care plan for one person stated; "Been portraying some aggressive behaviours at times, staff have been offering assurances or the nurse administers "when required" medication." Another stated, "Needs one to one support at times of challenging behaviour..divert and prevent challenging behaviour, risk of violence." As staff did not have a care plan that gave information about the interventions required they did not have written information to ensure they all worked in a consistent way with the person, to help reduce the anxiety and distressed behaviour.

We spoke to a family who was concerned about the care of their relative's wound that had developed. The registered manager told us the person's GP was involved, however the person's care records did not contain a care plan to instruct staff what action they should take to promote wound healing and ensure consistent treatment was provided. Another person had acquired a grade three pressure ulcer whilst at the service. Although assessments had been carried out which showed the person was at high risk of developing pressure ulcers, we found the person's care plan was not up to date to inform staff about the person's current care and support needs. This meant all records did not describe the care that staff provided.

Two of the records we looked at identified the people as being at high risk of falls but care plans for mobility were not in place to include the actions required to help prevent the falls. Records also did not show the support required to reduce the risk, when people bathed or showered, for example if they had epilepsy or required moving assistance from staff. Staff we spoke with however, could tell us how they provided care and support to people and they were aware of the risks to individuals.

We saw people's dietary and fluid intake was monitored however the food and fluid charts used to record the amount of food and fluid a person was taking each day did not accurately document the amount of food a person consumed.

We found care plans contained basic information which focused mainly on people's health care needs and provided little information about people's preferences or personal history. They were not individual to each person. They did not give staff specific information about how the person liked their care needs to be met. They did not detail what staff needed to do and what the person was able to do to take part in their care and to maintain some independence. For example, one person's care plan stated; "X requires the help of two staff for all hygiene, can become very agitated at any intervention." We saw it had taken four months for the person to relax and enjoy a bath, as the care plan had not been broken down, to show the interventions required by staff, to help the person relax.

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Is the service responsive?

We spoke with the registered manager about our observations. We were told nursing staff were in the process of making care plans more individual. However, two new care plans we looked at, although they were more detailed, they were the same and were not individualised and did not detail people's different support needs. They did not detail how care and support was provided that followed each person's wishes.

We found detailed information was not available to help staff provide care and support when a person was no longer able to tell staff themselves how they wanted to be cared for. Only two people's care records provided information about the person's life history, such as key events in their life, work history, spirituality and hobbies and interests. This meant information was not available to give staff some insight into the interests of a person when the person could no longer communicate it themselves.

Information was not available about people's life histories, their wishes with regards to their care when they were physically ill and reaching the end of their life, or arrangements for after their death. For example, to record their spiritual wishes or burial requirements. Therefore information was not available to inform staff of the person's wishes at this important time to ensure that their final wishes could be met.

This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke to the activities organiser, who had lots of ideas to help keep people stimulated. They told us they had been on a course about activities. They said they spent two hours on each floor, every day for activities over five days of the week. We asked how they provided activities that were of interest to each person as there was little written information about people's social care needs and previous interests and hobbies. They told us families were being asked to provide this essential information if a person was unable to tell staff. We saw the home was decorated for Halloween and we were told people were to be served a party tea. We saw photographs were available on one floor of the home that showed other seasonal parties, entertainment and outings that had taken place.

We spent time observing activities provision at the service. We saw there was more staff engagement and interaction with people on the younger person's unit. We noticed there were more activities for people. Members of staff were engaged and interacted positively. People enjoyed doing jigsaw puzzles, a Connect Four game, dominos and arts and crafts with people. A person we spoke with said; "Staff are very nice and they do activities with us like watch films and sing."

On the older person's units, we observed people were left to watch films or listen to music. We informed staff when the same dvd was put on again to play, by a different staff member. We noted the atmosphere changed when the activities organiser was present in the lounges. The staff became involved and they helped to encourage people to join in the singing or to help people take part in a reminiscence game of identifying objects that were shown on a big screen. We considered that improvements were required to ensure that staff interacted with people appropriately and to make sure they provided activities with people when the activities organiser wasn't available. Also to ensure they took every opportunity to engage and interact with each person and provide an atmosphere of awareness and interest in surroundings.

Relatives told us more activities and outings needed to take place to keep people occupied. One relative described the sponsored walk and picnic that had taken place at a local attraction, the Angel of the North. Another spoke of the minibus trip for a small group of people, to the Sea Life Centre at the coast. They also talked of their involvement helping with activities and outings and the arts and crafts that were to take place with people in preparation for Christmas. We saw a programme of events that were planned for December; these included a Christmas Fayre, a Christmas party for each floor, arts and crafts making Christmas decorations and a carol service with visiting school children.

The complaints procedure was displayed in the entrance to the home. We saw however, it was not referred to in the information made available to each person when they came to live in the home. This meant people did not have written information available, to make them aware of their right to complain and they were not supplied with information as to how any dispute would be handled within the organisation.

We saw a record of complaints was maintained. We found two complaints had been received, in the last two years, the last one had been made in August 2014 and had been resolved. However, we did not see a record of a complaint that had been raised by a relative who told us they had

Requires Improvement

Is the service responsive?

already raised it with the manager before approaching CQC. This was discussed and addressed with the registered manager after the inspection, in order to maintain the confidentiality of the person.

People we spoke with told us they knew how to complain. Relatives said, (Name of) , the registered manager was usually available and they could raise any concerns with her. The registered manager also told us people and relatives were asked at their review of care if they had any concerns or comments to make about the care provided.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager who had been in post since 2012. The manager became registered with the Care Quality Commission on 24 April 2014.

We spoke with staff with regard to the management of the home. They spoke positively about the support they received from the registered manager and nursing staff. One staff member said of the registered manager; “The registered manager’s door is always open.” Another said; “The registered manager is very approachable.” And; “The registered manager is supportive, she’s lovely.” Another staff member said; ”Nurses always back you up.”

People who used the service and relatives had commented in a recent survey carried out by the service in August 2014 that they thought the registered manager was approachable. A relative we spoke with commented “ The manager is kind and she’s usually available.” Another staff member said; “It’s very relaxed working here.”

We spoke with the local authority commissioner who had been carrying out regular monitoring visits since June 2014 after they had identified shortfalls in records, quality assurance systems and staff training. They commented on the slow progress the provider had made to carry out the actions identified on their action plan.

We found staff spoke positively about the approachability and support of the registered manager. However, we found the registered manager had not promoted amongst staff an ethos of involvement and empowerment to keep people who used the service involved in their daily lives and daily decision making. The culture did not promote person centred care, for each individual to receive care in the way they wanted. The people who lived with dementia did not receive care that identified and recognised them as a unique individual. Information was not available to help staff provide care the way the person may want, if they could not verbally tell staff themselves. There was little evidence from observation and talking to staff that people were encouraged to retain some control in their life and be involved in daily decision making. The environment was not adapted to keep people engaged and stimulated and aware of their surroundings.

The registered manager told us they completed audits. At this inspection we saw their audits were not always effective, for example; the dining experience, environment and records audit. We saw internal audits carried out by the registered manager were tick box exercises when checking and did not show evidence of how the evaluation had been reached or the follow up action taken by staff. They showed us the templates from the quality assurance manager, at head office, for a more detailed medicines risk and nutritional audit that was to be introduced. The registered provider had recently created a senior management team which included a quality assurance manager who would provide external auditing to help ensure more effective audits were introduced.

We found the audits did not check against standards to ensure people received safe and effective care. We saw they identified actions that needed to be taken, for example to update people’s care records, but they did not show evidence of monitoring or checking that the required actions had been taken. We saw it had been previously identified, in a service audit, that the menu should be publicised, but this had not been actioned. A dining audit had been introduced to look at people’s dining experiences, after we had raised concerns about this area at our last inspection. We found that this audit had not been effective as improvements were still required to make meal times a more pleasant and individual experience for people.

We found although records were audited monthly and included checks on care documentation and staff management, these audits had not highlighted the concerns which we had found with certain aspects of record keeping such as wound care, care planning, medicines, risk assessments, staff training and management of distressed behaviour.

Daily and monthly audits were carried out for health and safety, medicines management, laundry and maintenance of the environment. We saw the environmental audit was not effective as it did not include the design and suitability of the environment to promote the orientation and stimulation of people who lived with dementia.

We had concerns as currently, an effective system was not in place to assess and monitor the quality of service that people received.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff commented they thought communication was good and they were kept informed. They told us they received a

Requires Improvement

Is the service well-led?

shift handover from the person in charge to make them aware of any changes and urgent matters for attention with regard to people's care and support needs. A staff member told us; "Nurses do debrief following incidents so you can offload, look at triggers and actions; nurses take you over these situations." We saw records that showed meetings were held with staff every month. Areas of discussion at staff meetings included staff training, staff performance, confidentiality, hygiene, health and safety, safeguarding and support worker duties.

The registered manager told us questionnaires were sent out annually to people who used the service and their relatives and staff to get their views of the home. We saw copies of the surveys of the quality assurance audit for August 2014 where 22 replies were received. The registered manager told us the results were analysed by the service. We found the results had not been actioned in a timely way as people had commented not enough stimulation was being provided. Comments included; "Nothing is happening." Another commented; "Nursing floor needs more imagination, some trips out or even outside on occasions would be nice." We found similar comments were still being made at this inspection.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were not always enough staff employed and on duty to ensure the safety and welfare of people. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Respecting and involving service users.** People who used the service were not encouraged to make decisions with regard to their care and treatment. Their dignity and independence were not promoted. Regulation 17(1)(a)(b)(2)(a)(b)(c)(i)(ii)(d)(f)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Regulation 23 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2010. Supporting staff.** Staff had not all received up to date training, to meet people's specialist needs. Regulation 23(1)(a)(b)(2)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Records.** Records did not all accurately reflect people's care and support needs. Regulation 20(1)(a)(2)(a)
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Quality of service provision.** An effective system was not in place to assess and monitor the quality of service that people received. Regulation 10(1)(a)(b)(c)