Hill Care 3 Limited

The Oaks Care Home

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

Summary of findings

Overall summary

This inspection took place on 23 and 26 February 2018 and was unannounced. This meant the staff and provider did not know we would be visiting.

This was the first inspection of the service since it was registered with a new provider.

The Oaks is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The Oaks accommodates a maximum of 45 older people, including people who live with dementia or a dementia related condition, in one adapted building. At the time of inspection 33 people were using the service.

A manager was in post who had applied to become registered with CQC. Since the inspection they have become registered with the Commission. 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.

At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to regulation 18 and 17 with regards to staffing levels and governance. You can see what action we told the provider to take at the back of the full version of this report.

Changes had been made to the environment. Some areas had been refurbished. However, not all areas of the home were clean and well maintained for the comfort of people who used the service. The home was not designed to promote the orientation and independence of people who lived with dementia, although plans were in place to address this. We have made a recommendation that the environment should be designed according to best practice guidelines for people who live with dementia.

Improvements were needed to improve staff understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were not always supported to have maximum choice and control of their lives and they were not always supported in the least restrictive way possible, the policies and systems in the service supported this practice.

We have made a recommendation that staff receive training about person-centred care in order to ensure people receive individualised care and support.

We considered that staff deployment and staffing levels needed to be kept under review to ensure people's needs were met in a safe, effective and timely way. Care was at times task centred rather than person-

centred. There were limited opportunities for activities for some people to keep them engaged and stimulated.

Risk assessments were in place and they accurately identified current risks to people as well as ways for staff to minimise or appropriately manage those risks. Care was provided with kindness and people's privacy and dignity were respected.

Systems were in place for people to receive their medicines in a safe way. People had access to health care professionals to make sure they received appropriate care and treatment. People received a varied and balanced diet to meet their nutritional needs. However, we considered improvements were required to consultation and the involvement of people who lived with dementia.

Staff knew people's care and support requirements. However, record keeping required improvement to ensure it reflected the care provided by staff. A complaints procedure was available. People had access to an advocate if required.

Staff and relatives said the management team were approachable. Communication was effective to ensure staff and relatives were kept up to date about any changes in people's care and support needs and the running of the service.

The home had a quality assurance programme to check the quality of care provided. However, the systems used to assess the quality of the service had not identified the issues that we found during the inspection with regard to staffing levels, environmental design, infection control, person-centred care and record keeping.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff were not always appropriately deployed and staffing levels sufficient to meet people's needs in an effective and timely way. People were protected from abuse as staff had received training with regard to safeguarding. Appropriate checks were carried out before staff began working with people

Checks were carried out regularly to ensure the building was safe and fit for purpose. Areas of the home required attention as they were not clean and they were showing signs of wear and tear.

Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe way.

Is the service effective?

Requires Improvement

The service was not always effective.

A programme of refurbishment was taking place around the home. Further improvements were required to ensure it was designed to promote the orientation of people who lived with dementia. We have made a recommendation that the environment should be designed according to best practice guidelines for people who live with dementia.

Staff received supervision and training to support them to carry out their role effectively.

People received a varied and balanced diet. Support was provided for people with specialist nutritional needs.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring.

Staff were aware of people's backgrounds and personalities. 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.

We have made a recommendation that staff receive training about person-centred care as information and some practices did not ensure that person-centred care was provided.

People had access to an advocate to represent their views if required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff were knowledgeable about people's needs and wishes. Records did not always reflect the care and support provided by staff.

Staff in some areas of the home did not engage and interact with people except when they provided care and support. There were limited activities and entertainment available for some people.

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

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality assurance programme was not robust. Audits carried out to assess the quality of the service had not identified the all issues that we found during the inspection.

A registered manager was in place. Staff and relatives told us the registered manager was approachable and available to give advice and support.

People were very positive about the changes being made within the home.

Staff informed us that they enjoyed working at The Oaks and they worked as a team.

The Oaks Care Home

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 23 February and 26 February 2018 and was unannounced. The inspection team consisted of one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people. On the second day of inspection a specialist nursing advisor was part of the team. The specialist advisor helped us to gather evidence about the quality of nursing care provided.

The inspection was carried out as we had received some concerns about the service.

Before the inspection we reviewed the information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are reports of changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care and other professionals who could comment about people's care.

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 16 people who lived at The Oaks, the registered manager, the regional manager, one registered nurse, three relatives, the cook, one kitchen assistant, the housekeeper, nine support workers including two senior support workers and two visiting professionals. We observed care and support in communal areas and looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for eight people, recruitment, training and

induction records for five staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Requires Improvement

Is the service safe?

Our findings

People who used the service and relatives expressed the view that they and their relatives were safe at the home. One person commented, "I feel quite safe here." Another person commented, "I am quite happy and safe here." A third person said, "I feel quite safe here, there is always someone around."

People were positive about the refurbishment that was taking place in the home. On the ground floor two communal rooms had been knocked into one and made bright, spacious and airy. However, at the time of inspection not all areas of the home were clean and there was a malodour across the home. Areas of the home were untidy, this included some bedrooms and lounges and some bedrooms were unclean. We saw the bedroom of a person who had been in hospital for a week had not had their room checked since they left the home as the room was in disarray and dirty cups were evident. In some bedrooms bedding was worn and it was dirty in one bedroom.

The home was showing signs of wear and tear. Hallways and some communal areas required attention and some bedroom and communal carpets and walls were marked. We discussed the domestic routine with the manager as we observed during both days of inspection the domestic and maintenance person were providing direct care and support to people rather than attending to their designated role. We had concerns as they were carrying out another role due to shortages of support staff that their areas of work were being neglected. We discussed this during the inspection and the registered manager told us recruitment was underway to fill the staffing vacancies.

The registered manager and regional manager told us about the programme of refurbishment that was taking place since the provider took over the home in May 2017. The provider had a comprehensive action plan in place that detailed further refurbishment plans and timescales for completion. However, we considered some areas required more urgent attention including issues identified, at inspection such as revision of the domestic routine within the home. Straight after the inspection the registered manager provided an update to the CQC about the immediate action they had taken to make changes in the domestic routine. They also supplied a timescale for the completion of areas that required more urgent improvement in the environment that we had identified at inspection.

There were 33 people living at the home at the time of inspection, including two people who were in hospital. The manager told us 14 people resided on the ground floor and 17 people resided on the top floor but some people chose to spend time on a different floor of the home during the day. Staffing levels could therefore be adjusted dependent upon the numbers of people on each floor. They included to the top floor one senior support worker and a support worker. The ground floor was staffed by four support workers including one senior support worker. A nurse covered both floors of the home.

We observed staffing levels were not consistently maintained and suitable arrangements made to ensure sufficient appropriately skilled staff were available to provide direct care and support to people at all times. On the two days of inspection we observed staff were busy but did they not appear to be directed and appropriately deployed. We had concerns a regular member of support staff was not available to supervise

the maintenance person and a student who had just started their placement that day, as they were responsible for giving drinks and snacks to people from the drinks trolley on the ground floor. We had concerns, as no other staff were available, that they may not be aware of people's specialist nutritional requirements if anyone required for example, thickened fluids in their drinks or had other nutritional needs such as diabetes.

We discussed this with the manager who told us the maintenance person was also contracted to provide support. However, this meant they were unavailable to carry out their designated role to maintain the environment as they spent time away from that role. On the second day only five support staff members were available across the home plus a newly appointed staff member who was starting their induction that day.

At other times of the day we observed people waited for assistance and when staff went to attend to them they did not always return. One person told us, "On the whole the staff are good, but they make excuses for not returning." We intervened to find staff on one occasion for a person who called for some time for staff to assist them to the lavatory. We were told they then had to wait for a wheelchair. For another person we observed the chiropodist waited some time outside a person's bedroom for them to be brought down and then the person could not enter because the bedroom door was locked and they had to wait more time until staff obtained a key for the room. We discussed our observations with the manager and regional manager and after the inspection we were informed people had now been assessed for their own wheelchair. With regard to staffing levels we were told four support staff were currently being recruited and an additional two support workers were being recruited as bank staff to cover for the holidays and sickness of permanent staff.

However, staffing levels needed to be consistently maintained and staff appropriately deployed to ensure people's needs were met in an effective and timely way and that the environment was appropriately maintained.

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

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MARs) 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. One person told us, "I always get my medicines on time." 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.

Protocols were in place to assist staff by providing clear guidance on 'when required' medicines should be administered and provided clear evidence of how often people require additional medicines. However, for two people we saw that 'when required' guidance was not available for pain relief and for use of a spray. For a third person the time between doses of use of an inhaler was not recorded. This meant information was not available to ensure they were used consistently by staff. The nurse reassured us they would action these areas identified.

A visiting health professional, who held a weekly clinic, at the home spoke very positively about the care and support provided to people who displayed distressed behaviours. They said, "There have been massive

changes since the new manager came here." They spoke of the improved care and reduced use of sedative medicines. They described staff understanding of people's needs to ensure consistent care and support. They gave several positive examples of how people were supported at the service with more success than where they had previously lived.

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. The documents were individualised and provided staff with a clear description of any identified risk and specific guidance on how people should be supported in relation to the identified risk. For example, from falls, weight loss or risk of choking.

Staff had receiving training about safeguarding, they had an understanding of safeguarding and knew how to report any concerns. Staff were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse. One staff member told us, "I'd report any concerns straight away to the manager or regional manager." All staff expressed confidence that the management team would respond to and address any concerns appropriately.

A personal emergency evacuation plan (PEEP) was available for each person which took into account their mobility and moving and assisting needs. This was for if the building needed to be evacuated in an emergency. The plan was not reviewed monthly to ensure it was up to date. We discussed this with the registered manager who told us it had been identified already and was being addressed.

Arrangements were in place for the on-going maintenance of the building and a maintenance person was employed. Regular checks were carried out and contracts were in place to make sure the building was well maintained and equipment was safe and fit for purpose. Records looked at included maintenance contracts, the servicing of equipment contracts, fire checks, gas and electrical installation certificates and other safety checks.

Robust recruitment processes were in place. This included thorough checks of applicants for any role. Checks included proof of identity, criminal history checks, references from prior employers, job histories and health declarations. The service ensured only fit and proper persons were employed to care for people.

Requires Improvement

Is the service effective?

Our findings

We considered some improvements were required to people's dining experience and the food ordering system to allow flexibility and choice to people. People ordered their lunchtime meal in the morning but they were not offered a choice of meal at the meal time. Written menus were available on the ground floor but they were not accessible for people to remind them of the food options. Pictorial menus were not available to help people make a choice of meal if they no longer understood the written word. We observed one person responded when they were verbally offered a choice of mince and dumplings or quiche and chips, "I don't know, what do you think?" At lunch time people were also not shown the various food options to help them choose by sight or smell.

On the top floor we observed at the meal time if people did not want their main meal they were not all offered an alternative. In one case we observed a person became upset as they told staff they did not want the pudding available but they were still served it. For another person they said they did not want their meal and we did not hear they were offered anything else. On the ground floor people were served a juice of choice and a hot drink at their meal. This was not available on the top floor where people were offered a cold or hot drink, we considered for people's hydration they should be offered both at the meal time. We discussed the meal time and areas of improvement including hydration and listening to people with the manager and we were told it would be addressed immediately.

Our observations of people's dining experience showed food was well presented and looked appetising. People on the ground floor sat at tables that were set with tablecloths and people were offered protective aprons. Staff when they provided assistance or prompts to people to encourage them to eat, did this in a quiet, gentle way. Staff talked to people as they helped them. For example, "Would you like me to help you, shall I cut your food?" and "Are you enjoying that" and "Can I just wipe your mouth for you?" On the top floor we observed on the second day tables were not set until people sat down for lunch, people sat down at some tables that had not been cleared since breakfast time so people had to wait as tables were re-laid with the appropriate cutlery.

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 were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Food and fluid charts recorded people's nutritional and fluid intake and they were analysed daily. For one person, however, we saw that the person's daily fluid intake goal was recorded as 1500ml, but the person received 1000-1650ml from 19-25 February 2018 and it did not appear that the charts had been analysed, which showed staff may not have been effectively monitoring the person's intake and taking action. We discussed this with the manager who told us it would be addressed.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had submitted DoLS applications appropriately and told us six authorisations were in place and 22 applications had been submitted for processing by the local authority.

Records showed that where people lacked mental capacity to be involved in their own decision making, the correct process had not always been followed. Care plans detailed information about people's capacity to make decisions and their levels of understanding. Records however did not show involvement of people, or their relatives, where people did not have capacity for example with regard to signing their care plans or reviews of care. The nurse told us that the manager was organising for people, their relatives and staff to attend review meetings, where care plan documentation would be signed by the person where they were able, or where people were unable to sign themselves their legally authorised representative would sign on their behalf or alternatively best interest meetings would take place with people, staff and other professionals involved in their care.

Information was not available to detail why bedroom doors were locked or people's consent to having their bedroom door locked. We observed people's bedroom doors were locked and people did not have a key. We discussed this with the registered manager who told us some relatives had requested this to prevent people going into other people's rooms as they walked around. We advised people should be offered a key to their room and individual cases should be risk assessed rather than locking every person's door and restricting their movement around the home. By the second day of inspection this had been addressed and records had been completed and people had been offered keys to their bedroom.

We recommend staff receive updated training about person-centred care and person hood to ensure people's needs are met individually.

The environment was not "enabling" to promote people's independence and involvement. It was not stimulating and therapeutic for the benefit of people who lived there. Pictures, signs and orientation boards were not available in areas used by people to keep people orientated and involved and to help maintain their independence. Written notices and posters were available in the reception area of the home to keep people informed but this was not accessible to many people. There were no displays or themed areas of interest on the corridors and around seating areas for people as they moved around. We discussed this with the area manager and registered manager who told us it would be addressed.

We recommend the service refers to the National Institute for Health and Clinical Excellence guidelines, Quality Improvement Resource in Social Care Settings, regarding the design of accommodation for people who live with dementia.

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Recognised tools such as the Waterlow pressure ulcer risk assessment and Malnutrition Universal Screening Tool (MUST) were used, which helped identify the level of risk. The Waterlow scale is used to assess people's risk of developing pressure sores. Assessments were

regularly reviewed and updated to ensure they reflected people's current level of risk.

We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. The cook told us people's dietary requirements such as if they were vegetarian, vegan or required a culturally specific diet were checked before admission to ensure they were catered for appropriately. We observed they went around and spoke with people after the meal to receive feedback after the meal.

People enjoyed a varied diet. One person commented, "The food must be nice, I am a very fussy person when it comes to food." Another person told us, "I get good food and drinks." Other people's comments included, "The porridge is very nice, it's made with full cream milk", "Staff ask me what I want for my meals", "Good chef and a nice dinner" and "The food's alright here."

People and relatives praised the effective care provided, in terms of their health or family members' health and well-being. One person said, "They [staff] helped me to walk again, I have stopped falling down." A relative told us, "Staff talked to [Name] all the time even when they couldn't respond. Staff have helped [Name] to speak again." People's care records showed they had regular input from a range of health professionals such as, GPs, psychiatrists, dieticians and a speech and language team (SALT). For example, for one person who was living with Parkinson's Disease and had been experiencing an increase in their symptoms, we saw that advice had been obtained from the GP and their medicine had been increased to manage their symptoms.

Staff had opportunities for training to understand people's care and support needs and they were supported in their role. Support staff said they received regular supervision from one of the home's management team every two months and nurses received supervision from the registered manager. One staff member told us, "I receive supervision every two months." Another staff member commented, "I have supervision with the deputy manager."

Staff told us they were kept up-to-date with safe working practices and training to give them some insight into people's needs. One staff member commented, "There are training opportunities." Another told us, "I've done positive behaviour training." Other staff comments included, "We get training every week." "I've done dementia care training" and "I've completed level three medicines training." Nurses told us they had not received training about sepsis. The registered manager told us training was an area that had been identified when the new provider took over the company and changes were being introduced. More face-to-face training was to take place with staff, staff were to access local authority training where possible and the company trainer was also providing weekly training up-dates in the home. This was to ensure the staff team were all trained to meet people's needs. After the inspection we received an action plan that showed planned nurse's training included sepsis, venepuncture, syringe driver and verification of death.

Staff told us communication was effective to keep them up to date with people's changing needs. A handover session took place, between staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. This was to ensure staff were made aware of the current state of health and wellbeing of each person. One staff member told us, "We have a handover at the beginning and end of each shift."

Requires Improvement

Is the service caring?

Our findings

We observed during the inspection people on the ground floor received more stimulation and engagement than people who were on the top floor. Staff on the top floor unit did not always engage with people and interact with them although they were in the same room to supervise them. On the top floor unit, especially on the second day of inspection, there was limited engagement with people in the lounge. The only staff interaction with people was at mealtimes and when the drinks trolley came around or when people requested staff attention. Although a member of staff was sitting supervising people, they did not engage with them. They did not take the opportunity to talk to people and spend time listening to what they had to say. We observed around the home people remained in their bedrooms without stimulation and staff did not spend time with them except when they took meals and carried out tasks with them. One person confined to bed told us, "It depends how busy staff if they call in, it varies. They are usually too busy to stop."

From our observations we considered improvements were needed to ensure that all staff interacted with people at all times, and not only when they carried out care and support with the person.

People told us they made their own choices over their daily lifestyle. For instance, people had the opportunity to have a lie-in. They told us they could go to bed when they wanted and staff respected their wishes. Some care records provided information about people's ability to make a choice. For example, one record stated, '[Name] is able to choose their meals at mealtime.' One person told us, "I can get a shower when I want, I feel nice and clean."

We observed several people had a bottom sheet and 'throw' rather than a duvet or more appropriate bedding to keep them warm. We were told by the housekeeper duvets were available, but staff said people were too hot. We advised beds should be adequately made up each day and people asked about temperature such as if they were too warm or cold. This would provide more person-centred care rather than assuming all people had the mental capacity or verbal communication to say if they were hot or cold and may need more bedding. We discussed this with the manager who told us it would be addressed.

Limited written information was available about some people's likes, dislikes and preferred routines. A pen picture, social history was not available for all people if they wanted to share this information so staff had some awareness of people's backgrounds and areas of importance to them. Written information that was available tended to be standardised rather than person-centred relating to one individual's preferences. For example, some sleep routine care records stated, 'I don't like to sleep with light. Staff, however appeared knowledgeable about the people the supported. One member of staff told us, "I like to know about the people I'm looking after."

Communication care plans were in place. Some information was available for staff to follow in relation to how they engaged with people. For example, for one person we saw guidance for staff to talk about the person's family and their younger days as this often had a calming effect on them. Guidance was also available for staff to speak slowly and clearly to the person, at eye level as their eyesight was poor and that

they needed time to retain and understand information given to them. However, some communication care plans for people with nursing needs was basic, standardised and not person-centred. For instance, they stated how to speak with someone to inform them it's lunchtime. For one person it stated, 'It is 12.30pm lunch time". For another person, similar information, 'It is 1.00pm lunch time". Important information was not available for some people to describe and inform staff when a person may be in pain or distress, if they were no longer able to communicate this information verbally.

We recommend staff receive updated training about person-centred care to ensure people's needs are met individually.

Observations demonstrated that staff had a good relationship with people and knew their relatives well. People and relatives we spoke with all said staff were kind, caring and patient. One person told us, "I feel very happy here, the staff are very nice." Another person said, "The staff are outstanding here, they have very high standards. Other people's comments included, "It's very nice here, I couldn't wish for anything better", "I have nothing but praise for staff here", "I have brought my home here, I'm quite happy", "It's a nice place to come to live", "It's a real home from home and I have made a friend", "I'm alright here, they [staff] look after me very well," One professional commented, "The care staff are helpful and friendly." Another professional told us, "The care staff are interested and motivated."

The atmosphere in the home was calm, friendly and welcoming. Staff promoted positive and caring relationships. People were spoken with considerately and staff were polite. We observed people were relaxed with staff. One relative told us, "I am happy to go home, knowing [Name] is being looked after. I will be called if there's a problem." Staff interacted in a caring and respectful manner with people. Staff acted with professionalism, good humour and compassion. One person commented, "Staff are full of fun, nothing is a problem to them." Another person said, "The staff are very nice they laugh and carry on with you." We observed one person sitting alone at a table and a member of staff approached them and asked why they were alone and sat down and spent time talking with them.

People were supported by staff who were warm, kind, caring and respectful. 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. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging.

Staff treated people with dignity and respect. Staff members knocked before entering people's rooms, including when doors were open. Staff were discreet when speaking to people about their care and treatment. We heard staff ask people for permission before supporting them, for example with personal care or offering them protective clothing at the lunch time meal.

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Requires Improvement

Is the service responsive?

Our findings

Before people used the service they received information about the home and an initial assessment was completed to ensure the service could meet the person's needs. Care plans were developed from assessments that provided some details for staff about how the person's care needs were to be met. For example, with regard to mobility, nutrition and personal care. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations included information about people's progress and well-being.

However, although staff knew people's care and support needs, the quality of record keeping was inconsistent and did not provide sufficient detail to ensure person-centred care was provided.

Care plans were not broken down to detail what the person could do to be involved and to maintain some independence. Although they contained information, they did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They were also not summarised for staff to refer to easily. For example, for personal hygiene. This included for some people who became agitated and distressed when they received such intervention, care plans did not provide guidance to ensure consistent care was provided that minimised the person's embarrassment and distress. One care plan stated, 'For personal care may require the intervention of two or three members of staff.' The care plan did not provide guidance to detail what the person could do to be involved and how staff were to support them to reassure them.

People's continence needs were assessed and care plans developed. However, for one person we saw limited information about their urinary catheter and the nurse reassured us that they would address this as a priority. A urinary catheter is a thin flexible tube used to drain urine from the bladder. For another person a care plan about vision provided conflicting information as to whether the person was visually impaired in their right or left eye.

Social care plans were not in place for all people that detailed their social interests and hobbies and things they may be interested in to keep people engaged and stimulated if they chose to be.

End of life care plans were in place for people, which meant information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected. One relative of a person who had recently died told us, "Staff were so understanding, they kept [Name] comfortable. We were able to spend the nights here, staff supported us as well." 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 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. However, one DNACPR had been completed in the hospital setting and the person's home address had been scribbled out and the current home's address added. We spoke to the nurse who told us they would arrange for the GP to review the DNACPR form. The Resuscitation Council recommends that a decision about CPR is reviewed whenever a person moves from one setting to another, to ensure that the decision is still the right one for the person. We discussed this with the manager

who told us it would be addressed immediately.

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the positive behaviour team or the community mental health team. Specialist care plans were developed by the behavioural team to help staff support the person. 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. However, other care plans for people who may become agitated or distressed, where the behavioural team were not involved, did not document what staff needed to do to de-escalate the situation when a person became agitated or record any information or triggers to recognise when a person was becoming upset in order to provide consistent care.

This was a breach of regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

An activities coordinator was employed. They were employed 30 hours over the week. Staff told us the manager was planning to expand activities provision. The activities person told us, "I have a weekly meeting with the manager to discuss activities. They are encouraging me to do more activities." An activities programme advertised planned events such as arts and crafts, quizzes, one-to-one discussion, music, ladies luncheon club, movie afternoon, reminiscence, chats and board games. Staff told us the hairdresser visited. The activities person said, "We have once a week outings, we have no mini bus but we have a good relationship with the local taxi firm." A relative commented, "They've had trips to the Tall Ships, when they were in Blyth and sometimes trips to the local pub." Organised entertainment also took place in the home. After the inspection we were informed the home had been featured in the local media as they had hosted a vintage tea party with residents, relatives and friends to assist with the launch of a telephone project run by Age UK.

During the inspection we observed some activities taking place on the ground floor. A game of bingo took place. Some people sat in a group chatting and doing a jigsaw. One person told us, "We play bingo, do quizzes and sing songs." However, we did not observe any activities taking place on the top floor unit. We received information after the inspection to show improvements that were being made to keep people stimulated. For example, activities boxes were available for staff to use with people.

People knew how to complain. People we spoke with said they had no complaints. The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and a complaints procedure was in place. We saw compliments had been received from relatives of people who used the service thanking staff for the care provided.

Requires Improvement

Is the service well-led?

Our findings

A manager was in post who had applied to become registered with the Care Quality Commission. At the time of writing the report they had become registered. 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 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.

Auditing and governance processes were in place to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. Monthly audits included checks on care documentation, staff training, medicines management, home presentation, safe guarding, complaints management, falls, pressure area care, nutrition and accidents and incidents. Other audits included for health and safety and infection control. All audits showed the action that had been taken as a result of previous audits. However, the audit and governance processes had failed to identify deficits in the environment, staffing levels and staff deployment, record keeping, person-centred care and best interest decision making.

This was a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Other quality assurance processes included a risk monitoring report that included areas of care such as safeguarding, complaints, infection control, pressure area care and serious changes in a person's health status was completed by the manager and submitted to head office for analysis.

Visits were carried out two and three times a month by the regional 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, complaints, accidents and incidents, risk assessments, safeguarding and staff files. These 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. Action plans were produced from monthly visits with timescales for action where deficits were identified.

Regular monthly analysis of individual incidents and accidents took place. Individual incidents were reviewed, with action taken to reduce risk to the individual. One staff member commented, "Learning is discussed at flash meetings." This was to review any lessons learned to reduce the likelihood of a similar incident being repeated. There was evidence of analysis of groups of incidents which may have occurred looking for any trends and patterns.

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, regional manager and staff were open to working with us in a co-operative and transparent way.

All staff, relatives and people spoken with were very complimentary about the manager and changes they had introduced or were planned to the home. One relative told us, "It's more relaxed here, better atmosphere. The manager is more relaxed and I think it rubs off on the staff."

The running of the home was relaxed and open. The registered manager was very enthusiastic and had introduced ideas to promote the well-being of people who used the service. Staff and people we spoke with were all very positive about their management and had respect for them. They told us the service was well led. They said they could speak to the manager if they had any issues or concerns. One person told us, "The manager is very helpful and approachable. I feel confident to speak with them." Another person said, ""The manager always stays with me until we have sorted out any problems." Staff comments included, "The manager is supportive", "The manager always has time for you" and "Fantastic I love working here."

The manager told us they were well supported by the provider. They had regular contact with them, 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.

Staff told us and meeting minutes showed staff meetings took place. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. The manager told us daily 'flash' meetings took place with staff to keep senior staff updated. Staff said they were kept informed. One staff member commented, "Senior staff normally sit and discuss things every week with the manager, every morning when we finish handover we sit and talk with the manager."

The registered manager told us the provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out to people who used the service and staff. We saw results for the survey from September 2017 that had been analysed and its results corresponded with most of our inspection findings.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected from the risk of inappropriate care and treatment due to a lack of information or failure to maintain accurate records. Robust systems were not in place to monitor the quality of care provided. Regulation 17(1)(2)(a)(b)(c)(d)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured staffing levels were sufficient and staff were appropriately deployed to provide timely, effective and person-centred care to people at all times. Regulation 18 (1)