Akari Care Limited

Riverside House

Inspection report

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Morpeth
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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

Riverside House is a residential care home which provides accommodation and personal care for up to 46 people, some of whom have dementia. It is situated close to the centre of Morpeth.

The inspection took place on 24 February and was unannounced. Following the inspection, we were made aware of a number of concerns and we revisited the service for a second date on 27 May 2016.

We last inspected the service on 07 May 2014 and the service met all of the regulations we inspected at that time. A new manager had been appointed since the previous inspection and was in the process of registering with CQC on the first day of the inspection. The manager had resigned before the second day of the inspection and an interim manager from one of the provider's other homes had been appointed to manage the service.

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 and associated Regulations about how the service is run.

People told us they felt safe. There were safeguarding policies and procedures in place and staff knew what action to take if abuse was suspected. They had received training related to the protection of vulnerable adults. There were a number of safeguarding concerns under investigation at the time of the inspection and we will report on the outcome of these once investigations are completed.

We checked the management of medicines and found that systems for the administration and management of medicines were not being followed by all staff. A community pharmacist had audited medicines and had developed an action plan for improvement with the provider. They were continuing to work with the service to support them to make the required improvements.

We found suitable numbers of staff on duty on both days of the inspection but a number of staff had left the service and there was a reliance on use of agency staff although this had reduced. We made a recommendation to continue to monitor staffing numbers and skills mix while recruitment was on-going.

One the first day of the inspection we noted mild malodour in a small area of the home and the manager advised that plans were in place to address this. On the second day of the inspection, we found that this had deteriorated. Attempts had been made to clean the carpets but this had been ineffective. No action had been taken to replace the flooring. We found that infection control procedures were not followed and that there were damaged and marked mattresses and bed covers which posed an infection control risk.

Environmental audits and risk assessments were carried out and safety checks of the building and equipment were completed on a regular basis. These had not highlighted that a number of showers were broken and one bath was out of order. Emergency contingency plans were in place in the event of damage to the building or due to inclement weather such as flooding.

Individual risk assessments were carried out and action had been taken to mitigate risks, such as the provision of falls sensor mats for people identified to be at high risk of falling. Sensor mats alert staff when a person is moving unsupervised. A concern was raised that sensor mats were not always plugged in and in use and that people did not always have access to call bells. Steps were in place to address this issue.

Moving and handling assessments and care plans were in place but an assessment carried out by an occupational therapist found that staff were using unsafe moving and handling techniques and incorrect equipment with two people. This was reported to the provider for immediate action and the new equipment was ordered and care plans updated.

On the first day of the inspection we found that staff had received training in a number of key areas and we were told that plans were in place to address identified gaps in training.

Safe recruitment procedures were followed which meant that people were protected from harm. Systems for supervision and appraisal were in place which meant that the support and development needs of staff were identified.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. The registered manager had submitted DoLS applications to the local authority for authorisation. Assessments of mental capacity had been carried out and where possible, people contributed to discussions and decisions about their care.

People were not always adequately supported to eat and drink. Nutritional assessments were carried out, and people's weights were monitored to enable referrals to be made for specialist support if necessary. On the second day of the inspection we found some gaps in the evaluation of nutrition care plans, but these had begun to be completed again. Fluid balance charts were completed but where people had failed to reach their target fluid intake there was no evidence of action taken to ensure their hydration needs had been met. We saw that regular drinks were offered to people but charts did not demonstrate that the hydration needs of people were being monitored or met.

People had access to a number of health care services including the dentist, podiatry, and district nursing. One relative had expressed concern about the time it took to arrange appointments which they said needed several reminders. Another relative told us they found that appointments were made promptly. The manager said they would monitor this.

People, relatives and a visiting professional told us that the service was caring. We saw that staff treated people kindly and respectfully and there was a good deal of humour between staff and people during the

inspection. Staff appeared to know people well and supported them to maintain their hobbies, interests and independence, including, for example, participating in voting in local elections. We judged however that allowing people to be exposed to extreme malodour in some cases, over a prolonged period of time, compromised their dignity. We also found that a lack of timely response to difficulties in supporting a person with personal care needs also compromised their dignity.

A range of activities were available and an activities coordinator was in post. People, relatives and staff spoke highly of the activities coordinator who demonstrated a good understanding of the use of activities as a therapeutic intervention [to distract or to evoke memories] in addition to entertainment. There were links with the local community including access to poetry and drama groups, and links with local churches.

There was a complaints procedure in place which was prominently displayed. On the first day of the inspection, we saw that two complaints had been received and these had been addressed and responded to appropriately. A further complaint had been received and was in the process of being investigated on the second day of the inspection. There were a number of feedback mechanisms to obtain the views from people, relatives and staff. These included meetings and surveys. Feedback from relatives showed mixed views about the quality of the service.

On the first day of the inspection, people, relatives and staff spoke highly of the new manager and commented upon the positive changes she was making. On the second day of the inspection we found concerns in relation to the management of the service. Effective systems were not in place to monitor the quality and safety of the service.

Systems for the on-going monitoring of the service needed to be strengthened to ensure areas of non-compliance with policies and procedures were picked up promptly to keep the number of issues to a minimum including in the absence of a registered manager. The manager and regional manager were aware of this and the need to strengthen these systems.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Not all aspects of the service was safe.

Procedures were in place for the management of medicines but these were not consistently followed by staff.

Infection control procedures were not followed and some areas of the home were malodourous. The cleanliness and integrity of some mattresses and duvets was poor.

Incorrect moving and handling techniques were used which placed people and staff at risk of serious injury.

There were appropriate numbers of staff present during the inspection but we reported the concerns of two people to the manager about delays in response to their call bells at times. The managers said they would monitor this. There was high use of agency staff resulting from a number of staff leaving the service and recruitment was on-going.

There were safe recruitment practices which meant that people were protected from abuse.

Safeguarding procedures and training were in place. A number of safeguarding concerns were under investigation at the time of the inspection.

Is the service effective?

Requires Improvement

Not all aspects of the service was effective.

An identified training need had not been addressed to enable staff to care effectively for people with a specific condition.

Staff training was provided and where there were gaps in training related to a specific condition we were told plans were in place to address this.

A system of supervision and appraisal was in place and plans were in place to ensure that these were all completed within the required timescale. Staff told us they felt well supported.

People were not always adequately supported with eating and drinking and where target daily fluid intake was not met, we saw no evidence of action taken to ensure people's hydration needs had been met.

Is the service caring?

Requires Improvement

Not all aspects of the service was caring.

Personal care was offered discreetly and sensitively but the dignity of some people was compromised due to the offensive malodour in their bedrooms, and due to a lack of support with personal care for one person.

We observed staff treating people with kindness and displaying warmth and humour when interacting with people.

Where appropriate end of life wishes had been recorded to ensure people's wishes and preferences were documented.

Is the service responsive?

Requires Improvement

The service was responsive.

Person centred care plans were in place but there were gaps in care plan evaluations meaning some care information could be out of date.

People were supported to take part in activities and their previous interests and preferences were taken into account.

A complaints procedure was in place and prominently displayed. We saw that complaints checked on the first day of the inspection had been responded to appropriately by the provider.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

A new manager was in post on the first day of the inspection but had left the service by the second day of the inspection. Interim management arrangements were in place.

Effective systems to monitor the safety and quality of the service were not in place and governance was poor.

Meetings had been held on a regular basis with people and their relatives and links were being formed in the local community.

Riverside House

Detailed findings

Background to this inspection

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

The inspection was carried out on 24 February 2016 and was unannounced. The inspection was carried out by two inspectors and a specialist advisor with expertise in the care of older people, including those living with dementia. Following the inspection we were made aware of a number of concerns and therefore inspected on a second date on 27 May 2016 to follow up these concerns. The inspector was accompanied by a member of the local authority safeguarding adults team.

Prior to our inspection we reviewed the provider information return (PIR) that the provider sent us in advance. This is a form which asks the provider to give some key information about the service, highlighting what the service does well and identifying where and how improvements are to be made.

We liaised with the local authority safeguarding team who confirmed that there were safeguarding issues under investigation at the time of the inspection. We will report on the outcome of these if necessary once complete. We spoke with the local authority contracts team who provided feedback which we took into account during the inspection.

We spoke with 13 people who used the service, four relatives, and nine staff, including the registered manager, regional manager, deputy manager, cook, activities coordinator and care staff.

We read seven care plans, four recruitment files and the training records of four staff. We also checked audits and records relating to the management of the service.

We sat with people during a meal time and observed staff caring for people. 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 to us.

We displayed posters to advise people that we were carrying out an inspection and invited them to share their views.

Requires Improvement

Our findings

We checked the management of medicines. One person told us, "I always get my medicine at the right time." One the first day of the inspection there were safe systems in place for the storage and administration of medicines. A list of medicines to be given early [07.30 am] was displayed in the treatment room. Staff were trained in the administration of medicines and competency checks were completed. The regional manager told us the manager carried out a daily audit of medicine administration records [MARs] and reported any non-compliance immediately to her. Following the first day of the inspection concerns were raised in relation to the management of medicines by the local authority safeguarding adults team, in particular regarding the inconsistent use of codes in MARs. Codes are used to explain why a medicine may not have been given. Inconsistent use of codes meant that there was a risk that prescribed medicines were not given, and that concerns about medicines compliance would not be picked up and addressed with the prescriber in a timely manner. A review of medicines management was undertaken with support from a community pharmacist and an action plan had been developed for improvement. Areas of concern included gaps in the recording of administration of medicines, handwritten entries lacking evidence of a checking signature, frequently and missed evening doses when people were asleep. On the second day of the inspection we checked medicine administration records for people receiving cognitive enhancers (anti dementia drugs) and found no evidence of significant gaps which would render treatment ineffective, but still observed use of code Q and a small number of gaps in records, this meant that the medicines policy was still not being consistently followed by all staff administering medicines.

On the first day of the inspection we found that an infection control audit had been undertaken in January 2016 and a number of improvements had been made including the provision of additional equipment such as face masks and disposable arm protectors, and introducing a change to the uniform policy meaning staff had to change into their uniform at work. Weekly mattress checks had also been introduced. There were mild malodours in two areas upstairs and we spoke with the manager about this. We were told that domestic staff were monitoring the situation and that carpets would be replaced if necessary. We were also told that the problem with odours in the home had significantly improved. On the second day of the inspection we found that there had been deterioration in the malodorous rooms identified on the first day of the inspection. Carpets had not been replaced and the affected rooms smelled strongly of urine. We also checked mattresses and bedding and found that mattresses and divan bases in some rooms were stained. In one room the mattress was wet and the mattress cover was permeable meaning that the mattress was unprotected and fluid had soaked through. Some duvets, which were lightweight and synthetic were damaged, meaning the integrity of the fabric was breached so posed an infection control risk.

We found that a number of showers in people's bedrooms on the top floor were out of order. We were told that these had been reported but there were no confirmed dates to complete the necessary repairs. One bath was also out of order and we were told by a staff member that it had been out of order for at least three months and was awaiting a part. This meant that one bath was in use for 40 people which meant that there was the possibility that people may not have access to, and choice of, a bath or shower.

On the first day of the inspection we found that individual risk assessments were carried out which related to the risks to people who used the service including falls risk assessments for example. Falls sensor mats were in place for a number of people assessed as being at risk of falling. The mats alert staff that someone is moving and may fall. While a member of the inspection team was speaking with one person in their room, she accidentally stood on a pressure mat and staff came straight away. A relative told us, "[Name of relative] had a couple of falls but now he has a mat in his room and if his feet touch the mat it alerts staff. I feel he is safe here." Concerns had been raised that sensor mats had not always been turned on including at night which was under investigation. Spot checks out of hours had taken place to ensure that sensor mats and call bells were accessible to people at all times.

Following our inspection we were provided with feedback from an occupational therapist [OT] who had carried out assessments on the moving, handling and seating needs of people. The OT expressed concerns that they had observed staff using incorrect slings and techniques when hoisting two people which put staff and people at the risk of injury. We spoke with the manager who advised that the correct equipment had been ordered and care plans updated.

These were a breach of Regulation 12. Safe care and treatment.

We checked the recruitment records of four staff members. We found that safe recruitment procedures were followed which included obtaining references, and completion of an application to the Disclosure and Barring Service [DBS]. The DBS checks for criminal convictions and whether an applicant is barred from caring for vulnerable people. This enables employers to make safer recruitment decisions and protects people using the service from potential abuse.

People, relatives and staff told us there were enough staff on duty. One person told us, "There is always enough staff." A relative said, "They don't say wait a minute, they deal with things straight away." Another relative said, "There always appears to be enough staff on duty when I visit." A staff member said, "We have seven staff in the morning and six staff after two pm and four staff at night and that's manageable." Another staff member told us, "If we are short staffed we always get agency [to make up the numbers] but they are trying to move away from agency and use our own bank of staff [to improve consistency]. Two people told us they felt anxious sometimes when there was a delay in answering their buzzer. One person said, "I ring sometimes and the staff take a while to come. Other times they come straight away." We spoke with the manager and regional manager about this and asked whether call response times could be measured on the call bell system. They confirmed it could not, but said they would monitor this. They also said they would speak with one person who had agreed for us to pass on their concerns. We were not aware of call bells ringing for an excessive amount of time during the inspection on either day. On the second day of the inspection, the use of agency staff had increased due to a number of staff leaving the service. Managers told us that recruitment was on-going and that the number of agency staff hours required had reduced but that this continued to be monitored.

We recommend that staff remains under review to ensure sufficient numbers of suitable trained staff are on duty at all times.

On the first day of the inspection we found that safety checks on the building and equipment had been carried out including gas and electrical safety checks, fire safety equipment checks, and checks on equipment used to move people safely such as hoists. The passenger lift had been serviced and procedures were in place to safeguard people from the risks posed by Legionella bacteria. Window restrictors were in place and there were procedures to follow for the safe use of bed rails although none were in use during the inspection. Emergency procedures were in place in the event of power failure and an emergency evacuation folder was available and had been put to use in January due to a flood alert as the building is close to a river which is liable to flooding. The manager told us they had involved the fire brigade in completing a risk assessment and the manager stayed on site until the flood water began to subside. A fire safety inspection took place on 25 May 2016 and they requested that the provider update their fire safety risk assessment and carry out a number of improvements within three months.

People told us they felt safe. One person said, "I feel safe here, the staff are always so nice to me." A relative told us, "[Name of relative] is constantly reassured by staff to enable her to remain safe within her room and surrounding areas of the home, with visual and verbal prompts." There were safeguarding procedures in place and staff had received training in safeguarding vulnerable adults, and told us they knew what to do if abuse or neglect was suspected. One staff member said, "I would know what to do but I have not seen anything in all the years I have been in care." There were a number of safeguarding concerns under investigation at the time of the inspection. We will report upon the outcome of these once the investigation is complete.

Requires Improvement

Our findings

People told us they were happy with the care they received, and said, "The staff are very friendly helpful and efficient." A relative told us, "My relative was unsettled, and they have been fantastic. They came and spent time with him and reassured him, including the manager. He is much more settled now."

Staff told us that they received regular training which enabled them to carry out their role safely and effectively. One staff member said, "The company is really good, they put me through training. I wanted to do, [level 5 in leadership and management] and I have now finished it." We checked the training records of five staff members and found they had received training in a number of key areas including, fire safety, first aid, Mental Capacity Act, pressure area care, safeguarding adults, moving and handling, care planning, confidentiality, medication, infection control and equality and diversity. We reviewed a training matrix and found that there were some gaps in training including training to support people with a specific condition. We discussed this with the manager on the first day of the inspection and were told that there were plans in place to address these gaps.

Staff told us they had received training and support from outside agencies including the challenging behaviour team. This meant that staff had received advice to support people who were exhibiting complex behaviour or experiencing distress. One staff member told us, "We had [name of team member] in and they came to talk to us about the person's condition [dementia related] which gave us more understanding. We have worked out a plan which works and keeps everything calm. It is important that staff understand the reason [for behaviour]."
On the first day of the inspection, a system of supervision and appraisal was in place. The manager told us that they had taken personal responsibility for ensuring that supervision was up to date and told us, "I have a supervision plan which I have put in place and they have an appraisal up front. Just about everyone has had supervision now." Staff told us they felt well supported with their development needs.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Capacity assessments had been carried out on all people living in the service. Applications for authorisation to deprive some people of their liberty had been made to the local authority and the service was aware of the need to notify CQC of the outcome of these. In two of the care records we checked we saw that people had been involved in decisions about their care.

On the first day of the inspection we found that people were supported with eating and drinking. There had been a focus on improving the mealtime experience and we saw that people were well supported during their meal. Staff offered people a choice of roast turkey or broccoli bake and showed people the choices. This was helpful for people with a dementia related condition to have visual clues as they might not be able to understand the choices verbally alone. Staff spoke kindly with people during their meal and asked, "Are you alright?" and "Let me help" and "Do you want a little more?" Two people told us the food was nice and one person said, "It's lovely and there is plenty of it." We visited the kitchen and spoke with the cook. A board displayed a list of special dietary requirements including diabetic, high fibre, vegetarian and fortified [high calorie]. Coloured plates for use with people with visual impairment [yellow] or dementia related condition [blue] were being used. Some research suggests that Coloured plates can be helpful in helping people with certain conditions to see their food more clearly, which could improve dietary intake. The service was also working on the development of picture menus to support people to make choices more easily.

The cook was aware of how to adapt diets to meet the needs of people living in the service and told us, "We have diet notification forms in the kitchen for example [name of person] is losing weight so is on a weight boosting diet. It says their likes and dislikes. [Name of person] likes bacon sandwiches and [name of another person] likes bananas and isn't keen on sweet things." Care plans we checked showed that where there were concerns about diet or swallowing that appropriate advice had been sought and implemented. Weekly weight loss meetings were held to monitor people losing weight. Records were colour coded to enable staff to see at a glance people's progress. Records in red meant that people were still at risk of malnutrition, records in black meant weight was stable, and people with records in blue had gained weight. A relative told us about their family member, "He's put on half a stone since he has been here."

On the second day of the inspection we reviewed records of food and fluid intake due to concerns that had been raised with us. We found that target fluid intake had been determined for people and fluid charts had been completed. We found, however, that on a number of occasions target fluid intake recorded fell well below target but there was no evidence that any action had been taken to ensure that people's hydration needs were met and no medical advice had been sought. The nutrition care plan for one person had evaluations missing for the end of February, March and April and it had been completed in May. One person told us they liked to drink warm water and asked for a drink when we were in their room. Staff had brought them a cup of tea and they did not appear dehydrated. Their fluid intake was being monitored and we checked their records including care plan. It stated that they liked to drink water and that they should have access to a jug of water in their room. There was no water available and we asked staff to provide this. We checked the nutritional care plan for one person and found that it had not been evaluated in February, March or April 2016. We saw drinks being offered to people regularly during our inspection but records did not demonstrate that the hydration needs of people were being monitored or met. This meant that while it appeared people were being given drinks, this was insufficient evidence of this from records.

This was a breach of Regulation 17. Good governance.

We spoke with the interim manager and regional manager who told us they were revising food and fluid charts and showed us the new format which included dietary intake, fluid intake and output in addition to other care related records. They were more detailed and enabled staff to record more detail. The form

included an instruction that if less than 300 millilitres of fluid had been consumed by lunch time this must be reported to the senior in charge. This meant that they would be aware of the potential for people to miss their target fluid intake and take the necessary action in a timely manner.

People had access to health care services. There had been a concern raised in a survey completed by one relative that appointments for the dentist, hairdresser or chiropodist could require several reminders. The manager told us they would monitor this. Another relative told us during the inspection that they had found the service to respond quickly to the needs of their relative and said, "If there is anything wrong they immediately contact medical help. The dentist has been out already and a district nurse and chiropodist." A GP visited weekly but was called out in between times as necessary. We checked the care records of people and saw that they had accessed specialist services such as speech and language therapy and had accessed a GP and nursing services. We spoke with a District Nurse who told us, "The staff contact us in a timely manner and out of hours if necessary. I have no concerns about the service."

Requires Improvement

Our findings

On the first day of the inspection people told us they were happy with the standard of care they received. One person said, "It's a lovely home, the staff are lovely and caring." A District Nurse told us. "It's a nice home. The residents are always happy and look well looked after. The staff are friendly and helpful. The communal area is nice, there is always something going on." A relative told us, "Families bring children in and they treat it as a home. They get things out to play, nothing is a problem." Another relative told us, "What a lovely impression I received on my first visit to [name of person]. Staff were loving and patient with the residents and there appeared to be a happy relaxed atmosphere."

Staff upheld the privacy of people. We observed them speaking to people discreetly about personal care needs and knocking on bedroom doors before entering. Care staff wore aprons while supporting people at mealtimes but had stopped wearing blue gloves at mealtimes because kitchen staff served and handled food, and care staff felt this might feel impersonal to people. We observed that personal care was offered sensitively and discreetly. Records were stored securely to maintain confidentiality.

Despite the attempts of staff to maintain the dignity of people, some people were being cared for in parts of the home in an environment which was offensive and malodorous. We also found that the personal care needs of one person had not been adequately met as timely support had not been sought to help staff deliver care as required. We discussed this with the interim manager who arranged for support to be provided.

Staff were observed to treat people with kindness and respect. A person said, "Nobody wants me", and a member of staff said, "Well I want you." Another person said to a member of staff, "Your hair is lovely" and they replied, "Your hair is lovely too."

We observed people having fun with staff. Nutritional drink supplements containers were recycled to make maracas for people to shake. People enjoyed reminiscing during the music session, one person told staff about the dance lessons they used to have.

We observed two staff moving a person using a stand aid. They provided explanations and reassurance throughout, explaining what was happening. Afterwards they said, "You are in a nice comfortable chair now to play your game of skittles."

People were able to choose where they wanted to spend their time. Some people chose to spend the

majority of their time in their bedroom and others enjoyed participating in activities in communal areas. One person said, "I can stay in my room if I want to or go downstairs for meals. I have the option of having my meal in my room." The independence of people was supported. Some people had their own room key and at mealtimes staff ensured people had access to appropriate aids and crockery. Different sizes and weights of cups and mugs had been ordered to test with people to ensure they weren't too heavy for them to use unaided.

End of life wishes were recorded in three of the five care records we read. These had been signed and there was evidence of the involvement of family members. Two files had recorded that there were no end of life wishes at that time. No one was accessing formal advocacy services at the time of the inspection, but staff were aware of how to access the service if required.

Requires Improvement

Our findings

People told us their needs were responded to. One person told us, "I wanted to vote so the staff have helped me to vote in the local elections." Staff used their knowledge of people to anticipate their needs. A person got up from the dining table and a staff member said, "Channel 15?" the person smiled and said "yes". The staff member ensured that the television was on the correct channel for the person and explained that they enjoyed watching a film after lunch and that this was their favourite channel. Another staff member told us, "One gentleman always likes to watch sport, so we always check what is on." A person who had visual impairment told us that staff were responsive to their needs by ensuring things weren't moved in their room and making sure it was free from clutter.

On the first day of the inspection we found that pre admission assessments were carried out before people were admitted to the service which meant that care needs were identified before admission and care plans put in place. Care records were person centred. This meant that people's personality, behaviour, likes, dislikes and previous experiences were taken into account when planning care. Two of the five care plans we reviewed were signed by people confirming they had read the care plans. Where people lacked capacity there was evidence of consultation with family members in the records we viewed.

We checked care plans on the second day of the inspection and found that monthly evaluations had not been completed since the end of January, although evaluations had recommenced in May 2016. This meant that people's care plans had not been monitored effectively during this period to ensure that care provided remained appropriate and safe.

This was a breach of Regulation 17. Good governance.

An activities coordinator was in post who was a former lecturer in fine arts. We observed that his approach to activities was carefully planned and considered. People and relatives said they were happy with the activities available. One relative said, "I was particularly impressed at Christmas when they turned the little room into a cinema and played Calamity Jane." Another relative said, "They organise things for people, the children came in and did Highland dancing," and "The use of diversion is skilled."

We observed activities in the main foyer where the activities coordinator was playing music. We spoke with him and he told us, "I sing and play the ukulele and guitar. My background is folk music and I have asked the residents what music they want to hear. I also look for the foot tappers! It [music] stimulates deep seated memories for people with memory problems, they know the lyrics and it brings back memories rather than

trying to implant new ones. It acts as a starter for a conversation; they may say 'that was played at my wedding.'" We saw that people enjoyed listening to the music. One person said "What about You Are My Sunshine? That's a lovely tune." The activities coordinator stopped playing a song that people did not appear to know well, and played a song shouted out by someone which meant changing instruments. We saw that 12 people joined in singing the song which proved very popular.

People were taken into the town every few weeks by the activity coordinator and a group of up to five people attended Bedlington Salvation Army for a social afternoon involving tea, cake and dancing. The activity coordinator told us, "I think my main role is putting social in social care." Activities had been reviewed to ensure they were appropriate for everyone including those with visual impairment. Pet therapy was provided by the activity coordinator once a week when he brought in "Mr Scruffy" his Lurcher dog. He told us, "It doubles as a pastoral opportunity." One person told us, "Look at my nails [which were sparkling blue] the activities person did them for me, he's great!"

One person told us that they continued to go to work, and that they enjoyed a number of activities. They said, "We have a poetry session here and the county library is just up the road. I have just written a poem about this place. I have had a word with [name of manager] who is maybe going to put some poems in the dining room which I think is a good idea. "I have a lot of freedom and I go out quite a bit."

A complaints procedure was available and was prominently displayed. There was a record of two complaints and we saw that these had been responded to and a copy of the response was in place.

Requires Improvement

Our findings

On the first day of the inspection a new manager was in post who was in the process of registering with CQC. Relatives, people and staff spoke highly of the new manager. In addition to formal audits, the manager completed a daily walk around the home where she checked for any odours, the cleanliness and tidiness of rooms, and the appearance of people. She also checked staffing and regularly observed mealtimes. Observations were recorded and reported back to staff on duty for example, "trousers marked" and "bed untidy." While we walked with the manager around the home, she frequently stopped to check people were okay and appeared to know people well. An internal audit had been carried out and a development plan was in place which highlighted areas of "non- compliance" in the service with timescale for action. The manager and regional manager acknowledged that there were still improvements to be made which were on-going, including ensuring that established and effective systems of quality monitoring were in place to ensure consistent compliance in all areas.

A management feedback survey report from December 2015 reported that some relatives and people were unhappy with the standard of care and attention provided by some staff. Comments included "One shift of carers are very good, while the others leave a lot to be desired." Another relative said, "A few good staff but others who do not seem attentive to needs." There were also a number of positive comments including the improvement in the décor in people's rooms, and a comment that the telephone was answered more quickly. One relative remarked that they felt some issues had arisen while there was no manager in post. The new manager told us that they were keen to continue to make improvements in the service.

On the second day of the inspection, the manager had left in May 2016 and there was an interim manager in post. Two regional managers had been supporting the service in the meantime.

We found shortfalls in record keeping in relation to the evaluation of care plans, fluid balance charts and MAR's. Fluid balance charts were completed but there were no systems in place to ensure that people's hydration needs were met or to check that appropriate action had been taken when target fluid intake was not reached. We also noted that the change in presentation of one person was noted and recorded by staff but that no action had been taken to seek support with their specific health needs. Quality assurance systems were not sufficiently robust to highlight these issues.

Procedures were not consistently followed by staff in relation to the management of medicines, infection control, and the moving and handling of people. Managers in the service were unaware that the bath was broken. Areas of malodour had continued to deteriorate and had not been addressed. An effective system

for monitoring the safety and quality of the service was not in place.

This was a breach of Regulation 17. Good governance.

On the first day of the inspection we found that meetings were held on a regular basis for people and their relatives. We saw minutes from the previous month's meeting which was attended by kitchen staff and the activities coordinator to discuss issues relating to meals and activities. People fed back that they enjoyed the new fruit platters and were asked for any ideas and suggestions which they would add to the menu where possible. Hot chocolate had been added to the drinks trolleys and relatives were advised that they could eat with people without giving prior notice if they wanted to join them for meals. The activities coordinator outlined what had worked well such as baking, and what people hadn't enjoyed so much such as jigsaws. People were also told about ideas for new activities. The minutes also recorded feedback from two relatives who said they were very happy with improvements that had been made in the past month and that they had seen a noticeable change within the home's atmosphere and leadership at that time.

Links with the local community were being developed including those with church leaders from a number of faiths. Local businesses were invited to fetes and a fundraising event. The service had also accessed community drama and poetry groups and formed links with Newbiggin sports centre.