Four Seasons (Bamford) Limited

Wansbeck Care Home

Inspection report

Church Avenue
West Sleekburn
Choppington
Northumberland
NE62 5XE

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03 September 2018
07 September 2018
12 September 2018
19 September 2018

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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

Wansbeck Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Wansbeck Care Home can accommodate up to 40 people. At the time of the inspection there were 39 people living at the service, some of whom were living with a dementia.

We undertook an unannounced focused inspection on 3 September 2018. This meant that the provider did not know we would be visiting. We made a further three announced visits to the home on 7, 12 and 19 September 2018 to complete the inspection. The inspection was prompted following concerns received by the Care Quality Commission (CQC) regarding the management of medicines and concerns relating to pressure care for people. The team inspected the service against two of the five key questions we ask about services: is the service safe and well-led. Issues were identified during the inspection which resulted in the process converting to a comprehensive inspection where all five key areas were examined.

The last comprehensive inspection for the service was carried out in November 2017. At that time the overall rating for the home was good.

At this inspection we found care plans for people were inconsistent in the level of detail recorded and contained contradictory information about the needs of people. This resulted in care plans being confusing and difficult to read. Care staff knew people well and had in-depth knowledge of people's needs but this was not always reflected in the documentation we reviewed.

There were short falls and omissions with the management of risk. In some instances, risk assessments had been re-written over making them difficult to understand. Some risk assessments were not always detailed for known risks such as pressure care.

Consent to care and treatment was not always sought in line with the Mental Capacity Act 2005 (MCA). The best interest's decision-making process had been followed for people who lacked capacity to make certain decisions themselves. However, the provider did not have copies of Lasting Power of Attorney (LPA) documentation and could therefore not confirm if relevant people were legally able to act on behalf of people.

Audits were not detailed or robust and had failed to identify the issues found during this inspection. Quality assurance systems had not been effectively implemented to assess, monitor and improve quality at the service.

We saw positive interactions between staff and people. Most people spoke very positively about staff and thought they were kind and caring. There were limited meaningful activities available for people on the days the activity co-ordinator did not work.

Parts of the home were dirty and infection control procedures were not robust.

We received mixed feedback from staff regarding staffing levels and some staff told us they had too much to do and did not have time to spend with people. Safe recruitment procedures were in place however, omissions were noted. Selected training courses the provider had deemed mandatory were not up to date. Some staff told us they did not have time to complete all their work and were behind with paperwork.

The administration of medicines was not consistently safe.

People told us they felt safe. Safeguarding procedures were in place and staff told us about what they would do if they suspected or had concerns about harm being caused to people. However, we found that these procedures were not always followed.

The overall rating for this service has deteriorated from good to requires improvement.

During this inspection, we identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also identified a breach of the Care Quality Commission Registration Regulations 2009. Notifications of other incidents. You can see what action we have told the provider to take at the back of the full version of the report.

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.

The management and administration of medicines was not consistently safe.

Systems, processes and practices for keeping people safe did not always protect people from abuse.

Infection control procedures were in place, however, these were not robust and we found areas of the home were dirty.

Safe recruitment procedures were in place although they were not always fully followed.

Is the service effective?

Requires Improvement

The service was not always effective.

Copies of Lasting Power of Attorney (LPA) paperwork were not available, therefore the provider could not confirm if relevant people were able to legally act on behalf of people.

There were gaps in training the provider had deemed to be mandatory and induction paperwork was not always available for staff.

Some care records for people lacked detail and contained contradictory information.

Preadmission assessments were completed for people.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always promoted by staff.

We observed practice where staff treated people with dignity and respect but we received mixed feedback from people about their exchanges with staff. Staff told us of ways they worked to protect people's privacy and dignity.

People's relatives were able to visit when they wished and were made to feel welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some plans did not have sufficient information to ensure people's care was provided in a person centred way.

Complaints had not been consistently recorded, investigated and responded to appropriately.

In the absence of the activity coordinator there was a lack of meaningful activities for people.

Is the service well-led?

Requires Improvement

The service was not well-led.

Although audits were carried out monthly, they were not robust and failed to identify the failures we found during this inspection.

There was a registered manager in post although they were not present during our inspection. The regional manager and deputy manager were present throughout the inspection and were supporting the home both prior to and following the inspection.

Multiple breaches of regulations were identified during our inspection.

Wansbeck 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.

The inspection was prompted in part by a notification detailing concerns regarding the management of medication and concerns of pressure care for people. Statutory notifications contain information about certain events which the provider is legally obliged to report to us. The information shared with CQC indicated potential concerns for the safety of people living at the service. Those risks were considered when planning and during the inspection.

This inspection took place on 3, 7, 12 and 19 September 2018. Our visit on 3 September 2018 was unannounced. This meant the provider and staff did not know we would be visiting. The second, third and fourth day of the inspection were announced.

The inspection team consisted of two adult social care inspectors and a pharmacy inspector.

Prior to the inspection, we checked all the information which we had received about the service including notifications which the provider had sent us. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the local authority commissioning and safeguarding teams and the local Healthwatch. Healthwatch are a consumer champion in health and care. They ensure the voice of the consumer is heard by those who commission, deliver and regulate health and care services.

During the inspection we spoke with six people who used the service and five relatives.

Throughout the inspection we spent time in the communal areas of the home observing how staff interacted with people and supported them. We spoke with the deputy manager, regional manager, resident

experience regional manager, support manager, six care workers, activity coordinator, one kitchen assistant, one domestic staff, the cook and maintenance worker. A resident experience manager is a manager who works across a number of services run by the provider.

We reviewed 13 people's care records. We looked at five staff personnel files, in addition to a range of records in relation to the safety and management of the service. We also spoke with two healthcare professionals who visited the home.

After the inspection the provider sent us additional information including a plan of how they intended to make improvements.

Requires Improvement

Is the service safe?

Our findings

At our previous comprehensive inspection in November 2017, we rated this key question as good. At this inspection, we identified serious issues with the management of medicines, staffing levels, safeguarding, care records and the premises.

We looked at the home's systems, processes and practices for keeping people safe and found that these did not always protect people from abuse. Safeguarding procedures were in place. However, we found that these procedures were not always followed. We reviewed a safeguarding file and found the records were not recent. We asked the deputy manager for the safeguarding records for 2018 and were told in the absence of the manager these could not be provided. This meant that insufficient evidence was available to show that the home was managing incidents of a safeguarding nature appropriately. Safeguarding records were provided to us following the inspection.

We viewed care records and saw physical altercations between people living at the home had been documented. Some of these had been reported to the correct authorities, with appropriate action taken. We looked at care records and saw one incident of a safeguarding nature had not been reported to the local authority safeguarding team. We brought this to the attention of the deputy manager who made a referral to safeguarding that day.

People told us they felt safe. Comments included "I feel safe here, I couldn't have better carers", "Me and my daughter think it's up to scratch" and "Oh yes, I feel safe here. That's one thing that is good." We received mixed feedback from staff. One staff told us "In all the time I've worked here I've never seen any safeguarding concerns and if I did I would speak up as you've got to protect people." Another staff member told us, "Safeguarding training is e-learning. I've never had any safeguarding concerns. I would go and speak to my regional manager if I did and follow whistleblowing." A third member of staff told us "I have raised concerns before but nothing gets done. Action is needed now. The people upstairs need a voice." We reported these concerns to the provider who gave an assurance they would investigate and shared the information with Northumberland local authority.

Infection control procedures were not robust. For example, we observed two staff entering the kitchen without wearing aprons. We also observed kitchen staff open a bin and then continue labelling foods without gloves and having not washed their hands. This poses a risk of cross contamination and infection for people living at the service. We found the service was dirty in places, including in the medicines room, toilet areas, communal rooms and bedrooms. In one of the shower rooms which was fully accessible to people, we found red and blue trolleys for dirty linen which posed a risk of infection to them.

One staff told us, "Admin have taken on the role of giving the domestics guidance on what they need to do. There is a chart on the wall in the domestic office of what rooms need to be deep cleaned but it depends how many domestics are on duty. In my opinion there should be two but I don't know what the funding is for. If there's one domestic on we tell them to prioritise."

We checked the safety and suitability of the premises and equipment. We viewed personal evacuation plans and found that three people did not have these. The ones completed for people detailed the support required to evacuate the building in the event of an emergency. The fire service inspected the service in January 2018. Recommendations from this review concluded that the home needed to establish if evacuation could be completed in a suggested time of 2.5 minutes. If this were not possible the fire service identified actions that needed to be taken to safeguard people. We could see no evidence that any actions had been taken to progress this. The fire service inspection also identified that escape stairs were being used to store wheelchairs and told the service these must be removed. During this inspection we observed that the service continued to store wheelchairs in the same area. We brought this to the attention of the regional manager and immediate action was taken to remove the wheelchairs.

The systems in place for medicines management did not always keep people safe. Records relating to medicines were not always completed correctly placing people at risk of errors. We checked a sample of medicines alongside the records for people and found some medicines balances did not match up. For example, one person was prescribed a medicine to treat psychosis, we found the medicine stock balances were incorrect compared to how many administrations were documented on the medicines administration record (MAR).

Medicines were stored securely. However, we did find medicines which were to be returned to the pharmacy were not in a secure location; returns paperwork was also not completed in a timely manner meaning there was no oversight of when and what medicines had been placed into waste.

We looked at the process for the application of topical creams. The home had recently implemented body maps to guide carers on the application of creams. However, all records we viewed were incomplete with no instructions about how to use the creams safely.

The home was not following their current policy for the application of patches. For example, we looked at one person who was prescribed a patch for dementia treatment; manufacturers guidelines state this patch should not be applied to the same site within 14 days but the home had no process in place to ensure this was followed correctly.

We looked at one person who was prescribed medicines that needed to be given at a specific time; we found repeated omission codes, showing that the person was sleeping on consecutive days across the two previous months when the medicine should have been given. No action had been taken to escalate this to the relevant healthcare professional and this had not been documented in care notes. Care records for this person and guidance around their condition were limited and did not have sufficient information to guide staff.

These issues were a breach of Regulation 12 Heath and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were appropriately stored and signed for when they were administered.

A dependency tool was used to determine how many staff were needed to meet the needs of people. The deputy manager told us that the home ran with four care staff and there was a 'floating' (additional) member of staff during the day if there were 38 or more people living at the home. We asked both day and night staff if there was enough staff on duty. Responses included, "No, but some staff won't tell you that as they are frightened to speak up, but enough is enough"; "People's needs are not being met. How can one

person see to all those residents needs at night, it's ridiculous" and "Sometimes we don't have a floater and the seniors can be busy…we get help from another floor, but that leaves them short." Two senior care staff were available during the day on top of the four care staff, but their work included the administration of medicines and updating records, making appointments and other commitments which meant they were not always available to support care tasks.

We determined the provider did not have enough staff on duty to support the needs of the people who used the service. During our inspection we observed people were left unattended during lunch time for extended periods of time while waiting for meals to be served. We also observed periods where there was no staff oversight for people if staff were busy completing other tasks. One relative told us, "[Name of staff] is off at the minute so I think they are short staffed."

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

Safe recruitment procedures were in place however, we found that these were not always fully followed. Staff files contained a recent photograph, written references and a Disclosure and Barring Service (DBS) check. A DBS check enables employers to make safer recruitment decisions. It also prevents unsuitable people from working with vulnerable people. References and DBS checks were in place before staff had started employment. We did see two staff files where employment gaps had been recorded on application forms. These employment gaps had not been recorded on interview paperwork to show the provider had considered this.

Requires Improvement

Is the service effective?

Our findings

At our previous comprehensive inspection in November 2017, we rated this key question as good. During this inspection, we found concerns relating to staff training and meeting the requirements of the Mental Capacity Act 2005.

The provider could not always confirm if staff had completed a full induction, this was made more difficult in the absence of the registered manager. Copies of staff inductions were not always available, including for those staff who had changed roles. The deputy manager and the administrator confirmed that staff completed a two-day in-house induction and then an online programme based around the standards of the Care Certificate. Staff spoken with confirmed they had received an induction but not when, or the full details could not be confirmed. One staff member said, "I have had an induction but it was a while ago. I think I was told about how things worked in the home and who I needed to speak to if I needed anything…but cannot remember really."

Staff had completed a range of training from copies of certificates held on their files, however, without going through each staff members record we could not be assured that all necessary training had been completed or was up to date. No training matrix or tracker was available during the inspection. The regional manager told us, "There will be a matrix but we cannot gain access to it at the moment."

Following the inspection a training matrix was sent to us. This showed there were gaps in training that the provider had deemed mandatory. The matrix showed that all staff were out of date with moving and handling training. We were told moving and handling training was being sourced to update this for staff.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The provider did not have copies of Lasting Power of Attorney (LPA) documentation and could therefore not confirm if relevant people were able to legally act on behalf of people. LPA is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. There are two types of LPA; those for financial decisions and those that are health and care related. We brought this to the attention of the regional manager during feedback who said they would look into this issue.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

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 procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People had authorised DoLS applications in place. Staff were complying with their legal responsibilities and were aware of this deprivation and what it meant for people.

Staff received support from the management team. Staff said they felt supported and received regular supervision and yearly appraisals. Staff comments included, "I have supervision regularly" and "I have had supervision, but don't ask me when, my memory is terrible." We reviewed staff records and confirmed support was regularly provided. Appraisals were in the process of being completed.

People's records confirmed that an assessment of their needs had been completed before they moved into the service. A more detailed needs assessment was completed after moving in, with supporting care plans and risk assessments put in place which were reviewed, although we did find some gaps. Care plans supported a range of needs, including those in connection with physical and psychological needs.

Some care records for people lacked detail and contained contradictory information. We found when there had been a change of need for some people, staff had written over the initial assessment making care plans difficult and confusing to read. We viewed one care plan where the person was recorded as having lost weight. This care plan had not been reviewed for two months and there was no evidence any action had been taken. We saw another care plan for a person with a pressure ulcer. This care plan lacked detail of how often the person required positional changes and what action staff should take if symptoms deteriorated. Care records for this person indicated a change in their condition but did not show what actions were taken or if advice was requested from the GP.

Staff communicated the up to date needs of the people living at the service with each other. A written and verbal handover was completed at the start of each shift.

People had access to a range of healthcare professionals. This included a Parkinson disease specialist nurse who was recorded as having visited one person after requests from the staff at the home. Records were kept of any visits that had taken place or been requested, including those from GP's, district nurses or from opticians. One person was at risk of choking and a referral had been made for the speech and language therapy team to visit and support this person.

People did not always have a full choice in their daily life. Staff asked people the day before what they would prefer to eat the following day. However, people who were living with dementia or had communication difficulties were not always given opportunities to make choices easier or more accessible. For example, using picture cards. Staff confirmed they did not use picture formats to support people in making choices around meal times. We observed one person supported with their meal but little choice was offered to encourage them.

We received mixed views about the food and refreshments provided at the service. One person said, "There is a couple of meals to choose from at dinner time, it's [food] okay." When we visited a dining area and asked people if they were happy with the meals provided, we received nods and thumbs up signs. Staff we spoke with said, "Meals are varied, they are okay" and "Everyone seems happy enough." One member of staff said, "Meals could be better. Residents sometimes get offered a quarter of a sandwich at night which is not good enough, they are leftovers from tea." We raised this with the provider who investigated and gave an assurance that sufficient food was always available for people.

Some people received softer meals as part of their special dietary needs. These meals were separated into different food types for taste. Staff were aware of when people needed thickeners. Thickeners are usually powders added to foods and liquids to bring them to the right consistency or texture for people with swallowing difficulties.

Dietary notification records kept in the kitchen were not always up to date which meant there was a risk people may not have received their correct diet. One person had been prescribed thickeners to be given in certain circumstances, but this information was not held by kitchen staff, although when we spoke to care staff they were fully aware. Another person's dietary notification sheet had been updated but kitchen staff did not have this, although there was no evidence from observations that the person was not receiving their correct diet.

The premises did not always meet people's needs. Each unit had ten bedrooms, some of the bedroom doors lacked numbers or information on who lived there, this is particularly important for people who are living with dementia. People did not always have the use of all the facilities at the service. For example, one bathroom had been out of use for a number of years and meant people had to use a bathroom on a different unit, which made it less convenient for them. The service was in need of refurbishment in places, including handrails and walls where paint had worn off.

Requires Improvement

Is the service caring?

Our findings

At our previous comprehensive inspection in November 2017, we rated this key question as outstanding. At this inspection, we found that the service had not always delivered care in a manner which was caring.

During lunch time observations we saw people who needed support with their mobility were left at dining tables for excessive amounts of time. These people were sitting in the dining room for 10 minutes waiting for food to be served as staff were busy supporting other people. People also had to wait for staff to help them back to their bedrooms. Particularly people using wheelchairs had to wait for staff to support them.

One staff member was observed standing over a person they were supporting to eat a meal, rather than sitting next to them and giving encouragement. Another staff member was observed sitting next to one person at lunch time and saying, "Come on [name of person] – you going to try a little bit cake – go on try a little bit." The staff member repeated this a number of times which resulted in the person becoming anxious. We saw two people without slippers or any form of foot protection. We asked staff why these people were not wearing anything on their feet. We were told the reason for one person was, "their feet swell up and they don't like them." The other person observed had been asked to get out of bed to have their lunch at a tray table set up in their bedroom. Staff did not offer to support them to place any form of protection on their feet to shield them or keep them comfortable and warm on the wooden flooring.

We received mixed feedback from people living at the service when we asked if they were treated with kindness, dignity and respect. One person told us, "They've been good to me. No complaints from me. He's been good to me [staff member's name] couldn't be better." Another person told us, "On the whole I suppose they are very good but there's the odd ones who are not very good. I think because they are inexperienced as it's mostly the young ones. It's not that their job isn't very good as that is ok… it's their manner and attitude towards you. I suppose it's inexperience. You get the odd one but it's just the odd one." A third person told us, "They've got their rules and regulations, they aren't allowed to come to you to help you to the toilet during meal times." A fourth person told us, "You have to wait a little while for the toilet but they do come for you."

Comments from relatives included, "Every time we visit we are always made to feel welcome. [Name of staff] has been wonderful. I was in a bit of a state when my [relative] first came in and [name of staff] was wonderful", "I'm really pleased. They always seem to know what makes [name of person] smile and they will have a joke with [name of person]" and "They seem as though they care but they go further than what they have to. Nothing is too much trouble for people, my [relative] loves it here. I visit regularly and I see different staff and all staff are very caring." A fourth relative told us "Recently [name of person] became seriously ill and the staff have been really compassionate. Not just how they've been with [name of person] but also with me. There has been real empathy there."

Staff told us they thought the home was caring but that they didn't always have enough time to spend with people because of the amount of work to do. Some positive interactions between staff and people were observed during the inspection.

Staff told us ways in which they worked to protect people's privacy and dignity especially when supporting people with personal care. Comments from staff included, "we respect people and treat people how we would expect to be treated. We make sure curtains and doors are closed and ask people before we carry out any support", "We encourage people to be independent, for example putting toothpaste on the toothbrush but then leaving it on the sink with a flannel to help prompt people to clean their teeth" and "It's a job where I get job satisfaction when I sit and chat to people and think I wish my grandma was still here. I like to see a change in people, it's not all about big things it's the little things too. Spending five minutes with people, having a cup of tea and chatting."

We observed a number of chairs which had their cushions removed, making it uncomfortable for people to use. These were seen in corridors and in communal lounge areas. When asked why cushions had been removed, one staff member said, "They are getting cleaned." However, they remained like that throughout the third day of the inspection.

People's religious beliefs were recorded where appropriate. Staff were respectful of people's needs when these were known.

The activities coordinator told us of 'Living My Choices' booklets which were completed for people. These booklets contained person centred information about people and their life history. Relatives had been involved in providing information for some people and booklets had been personalised with photographs.

At the time of the inspection no one required support from an advocacy services. An advocate helps people to access information and to be involved in decisions about their lives. Staff knew how to support people to access advocacy services, if this was needed.

People's confidential information was stored securely and could be located when required. This meant that people's confidentiality was maintained as only people authorised to look at records could view them.

Requires Improvement

Is the service responsive?

Our findings

At our previous comprehensive inspection in November 2017, we rated this key question as good. At this inspection we found that some care plans lacked detail about the needs of people and people were not always meaningfully engaged during the day.

Care plans we viewed differed in quality and fluctuated in the amount of person centred information they contained. Person-centred planning is a way of helping someone to plan their life and support, focusing on what is important to them. We saw one care plan that contained lots of person-centred information. This care plan contained information which detailed important routines for the person. However, some care plans lacked detail and contained contradictory information. We also saw care plans where an initial assessment had been written over when there had been a change in need. This made care plans confusing to read. Another care plan was in place for a person at risk of pressure damage. However, this care plan was not detailed in specifying how often the person required positional changes or what action staff should take in the event of skin deterioration. We brought this to the attention of the regional manager who assured us care plans would be reviewed.

Mostly, care plans had been reviewed on a monthly basis. We did find gaps where monthly reviews had not been completed or when a change of need had been identified but it was unclear from the records what action had been taken.

Staff told us, "Paperwork could be improved but when you are short staffed things do get put back a bit. I have feedback that I was behind with paperwork" and "Staff have a habit of writing over initial assessments and it does make it confusing to read." Comments from visiting professionals to the service included, "During reviews staff seem to know people really well and know people's needs" and "The home does look for support and did ask for support to review care plans. [Name of staff] has always worked to try and maintain people's placements at Wansbeck."

We looked at how the provider managed complaints. There was a complaints procedure in place however, we could not see evidence that this was always being followed. We reviewed a complaint's file and found that records were not recent. We asked to view any complaints for 2018 and were told these could not be accessed in the absence of the manager. The resident experience regional manager told us an electronic system was in place where anonymous feedback could be given by people, relatives and staff and it was felt this system had reduced complaints. We spoke to the resident experience regional manager and regional manager to advise a relative had told us they had complained. We were later told this complaint had been incorrectly documented and had not been recorded as a complaint. One person told us, "I have complained, I think it's a thing that will iron itself out." We did not see any evidence this complaint had been recorded.

We recommend that complaints are consistently recorded, investigated and responded to appropriately in line with the complaints procedure.

We checked how people's social needs were met and during observations saw there were times when

people had no opportunity to engage in meaningful activities. The service employed a full-time activities coordinator who worked four days each week. One person said, "There is a lot of activities going on but sometimes I can't get to them as I've got pain and am in bed. I've got things to do in my room though so I'm never bored." A relative told us, "We came for the summer fayre, they wouldn't take any money for our food so we donated to the activities which are good."

However, during the inspection we observed periods where people were either sitting in their bedrooms or in one of the lounge/dining areas. The activity coordinator was not working on the second and third day of the inspection. On these days we saw limited meaningful interaction with people. Staff had little time to talk to people and we did not observe anyone engaged in activities with staff. There were times when there was no oversight for people as there were not enough staff.

We received mixed feedback from staff regarding activities. Comments included, "Activities here are very good. Singers come in and we have Christmas pantomimes and tea dances etc." and, "We try and make it enjoyable for people. We had a puppet show last week but not one for kids. There were people up dancing and things and the staff were dancing too." A third member of staff told us, "Staff don't have five minutes to spend with people, residents are in front of the television with nothing to do unless there's an external activity on."

'Residents' meetings' offered people the opportunity to make suggestions about activities. People had fed back there were no local shops where they could buy things. The activity coordinator told us of strong links with a local Co-op store and how people had spoken about their memories of how this shop used to be. A fund-raising event was held and the proceeds were used to buy a dementia friendly shopping kit. The kit contains old packaging, old uniforms, dividend books and old money. Acting on the feedback from people an area of the home was designated to become a functioning shop where people can go to buy items.

The activity coordinator also told us about 'Living My Choices' booklets which had been completed with people with the support of some relatives. Books contained life histories for people and some had been personalised with photographs.

End of life care plans were in place for people. Care plans contained evidence that discussions had taken place with people and their relatives to record a person's wishes for the end of their life. One relative said, "I have always been included in decisions about [name of person's] care. I do feel that my opinion has been taken into account. I'm really happy with [name of person] being here."

One bathroom on the first floor was out of order and had been used as a store room for a number of years. One staff told us, "The bathroom was condemned a long time ago so there's only a shower along there. If people want a bath they can go to another unit. Some people prefer a bath so have to be taken to other units for that." We shared these comments with the regional manager.

Requires Improvement

Is the service well-led?

Our findings

At our previous comprehensive inspection in November 2017, we rated this key question as good. At this inspection, we found serious concerns and shortfalls relating to the governance of the service.

There was a registered manager in post at Wansbeck Care Home. They were not present during the inspection. In their absence the home was being run by the deputy manager with support from the home's regional manager.

During the inspection we were unable to view some of the records we had requested to see. This included the staff training matrix, induction records, complaints log, safeguarding log and some safety certificates. We were told in the absence of the registered manager these records could not be accessed as they were stored electronically on their account. The resident experience manager told us, "Complaints and safeguarding are logged on the managers computer and no one has access to the passwords but I would expect these to be completed and printed out." This meant the provider had no oversight of systems as they had not picked up in provider audits that some information could only be accessed by the registered manager.

Following the inspection, the provider identified a resident experience support manager who would manage Wansbeck Care Home in the absence of the registered manager. They forwarded additional information to us which included records for safeguarding, complaints, staff training, falls analysis, some safety certificates and a staff supervision and appraisal matrix. The resident experience support manager sent a report which detailed how the planned to make improvements.

Various audits were completed across the service. We found that audits were not robust and were not identifying the issues we found during this inspection. Where an issue had been identified there was no action plan documented to record how improvements would be made or who was responsible for the task. For example, the provider audit completed in July 2018 recorded there was no cleaning schedule or routines for responsive cleaning, including toilets and bathrooms. The audit document stated this needed to be monitored and more robust, but did not explain what actions were required to implement this improvement. This audit was mainly completed with a 'yes', 'no' or 'not applicable' response and contained no detail of which records had been viewed. The problems we identified with some care plans lacking detail and containing contradictory information had not been picked up in audits.

Accidents and incidents were recorded electronically; however, there was no thorough analysis to determine if any trends could be identified to reduce the risk of repeated accidents. For example, incident analysis documentation recorded the number of unwitnessed falls each month and the times incidents had occurred. However, these were the only factors taken into consideration, there was no evidence of looking at potential trends or to identify any lessons learnt.

Monthly infection control audits had not been completed. The staff responsible for completing these told us, "I didn't even know they were monthly, I know they have put some things on the iPad but I haven't been

shown how to do it. I thought infection control audits were six monthly."

We looked at the processes for auditing medicines within the home and found that whilst there were daily, weekly and monthly audits they had not picked up issues with the management of medicines. We also found the home had not completed a monthly audit in July 2018 due to there being a cross over in audit tool technology therefore the home could not provide crucial audit data for this month.

We looked at the settings on air flow mattresses and found these were determined by the district nurses. However, this information was not recorded in care plans. Staff did not know what the assessed settings were and therefore, could not check the equipment remained safe for people. One staff told us, "I don't know if they are set on the correct settings…I suppose it would be possible for the settings to be accidently changed as the beds in rooms are moved." We brought this to the attention of the deputy manager who contacted the district nurses to request their input to update skin integrity care plans to include mattress setting information.

A fire safety risk assessment was completed in June 2017. A risk assessment and action plan was identified following this assessment. However, records were not fully completed so we could not be assured that the required works had been completed.

An 'In Case of Emergency' (ICE) file was available with care records. On review of this file we saw the details of 19 people who have since passed away. The deputy manager told us this file was no longer in use and needed to be removed from the current care records for people.

These issues were a breach of Regulation 17 Heath and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

The deputy manager told us, "I hadn't realised the things that have been picked up on during the inspection but we have been actioning what needs to be addressed. I want to action the areas of problems and make it better. A planner is being implemented to update care plans with a realistic time frame of three months to complete them."

An effective system was not in place to ensure that incidents of a safeguarding nature were notified to the Commission. This meant that CQC did not have oversight of all safeguarding allegations to ensure that appropriate action was being taken to protect people.

This was a breach of regulation 18 of the Care Quality Commission Registration Regulation 2009. Notifications of other incidents. This is being followed up and we will report on any action once it is complete.

We received mixed feedback from staff regarding the management of the service. Comments included, "Management here is very supportive. [Name of manager] has been very supportive, they don't just care about residents they care about staff too, the door is always open. The deputy manager is very supportive too.", "The home is run quite well, the manager is fair with us. The manager is off at the minute and the deputy manager was on holiday so there was management cover. All the staff pulled together to do what we had to do." A third staff told us, "Some days management support is there others not. I don't always feel that my opinion is listened to. I do feel that staff are undervalued for what all staff do across the home."

The provider used surveys to seek the views of people, relatives, staff and visitors of the home. A live system was in place where satisfaction surveys could be completed anonymously using an iPad. The deputy

manager told us 'resident and relatives' meetings were held where agenda items would be discussed.

An award system was in place by the provider, Recognition Care Kindness (ROK) to show staff they were valued. Staff could nominate a colleague for a reward as well as people or relatives. If staff won they received a gift and a plaque as recognition of their achievement.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care and treatment was not always sought in line with the Mental Capacity Act 2005. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not all risks had been assessed or action taken to reduce the risk of harm. Medication was not consistently safe. Regulation 12 (1)(2) a)(b)(c)(f)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to effectively monitor and improve the quality and safety of the service nor to monitor and mitigate the risks to health, safety and welfare of people who used the service. Regulation 17 (1) (2) (a) (b) (c) (d) (i) (ii) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing An effective system was not fully in place to ensure that staff received appropriate training to enable them to carry out their duties they were employed to perform. Regulation 18 (1)(2)(a)