Miss Lucy Craig

Cramlington House

Inspection report

Bassington Avenue
Cramlington
Northumberland
NE23 8AD

Tel: 01670591930

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Cramlington House is a residential care home based in Cramlington, Northumberland which provides accommodation and personal care to up to 63 older people. People are accommodated in three separate units and most people living at the service have some form of dementia. The last inspection of this service took place in May 2015 where the provider was found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in respect of the management of medicines. At this inspection we found improvements had been made and the provider was no longer in breach of the aforementioned Regulation.

This inspection took place on the 16 and 20 June 2016 and was unannounced. The inspection was carried out by one inspector.

A registered manager was in post at the time of our inspection who had been registered with the Commission to manage the carrying on of the regulated activity since August 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were complimentary about the service and the staff who supported them. This was echoed by their relatives. Staff were complimentary about the support they received from each other, the registered manager, the operations manager and the provider. Healthcare professionals said they enjoyed a good working relationship with the service.

People told us they felt safe living at the home and we saw they were appropriately and safely supported in their daily lives. Safeguarding policies and procedures were in place to monitor and respond to any matters of a safeguarding nature and we saw that historically these had been dealt with correctly by the registered manager. Staff were aware of their personal responsibility to report incidents of a safeguarding nature and they had received training in safeguarding vulnerable adults. Risks that people had been exposed to in their daily lives and within the environment of the home had been assessed and mitigated against. Accidents and incidents were monitored, analysed and measures were put in place where necessary to prevent repeat events.

Recruitment procedures were robust and medicines were managed safely and appropriately in line with best practice guidance. Staffing levels were sufficient on the days that we visited the home to meet people's needs and staff confirmed that they were not unduly rushed in the pursuit of their duties. When people called for assistance we observed staff attended to them promptly to meet their needs. Staff were trained in key areas relevant to their role such as moving and handling, and also in areas such as Non Abusive Psychological and Physical Intervention (NAPPI) training, which was relevant to the needs of some of the people they supported. There was a thorough induction package in place and supervisions and appraisals

took place regularly to provide support to the staff team.

CQC monitors the application of the Mental Capacity Act (2005) and deprivation of liberty safeguards. The Mental Capacity Act (MCA) was appropriately applied and applications to deprive people of their liberty lawfully had been made to prevent them from coming to any harm where they lacked capacity. The service understood their legal responsibility under this act and they assessed people's capacity when their care commenced and on an on-going basis when necessary. Decisions that needed to be made in people's best interests had been undertaken in line procedures set out in the MCA, and records about such decision making were maintained.

People were supported to eat and drink in sufficient amounts to remain healthy. There were monitoring tools in place which ensured that where there were changes in people's health and wellbeing this was identified and actions were taken to prevent any deterioration in people's conditions. For example, food and fluid charts and positional change charts were used, where people were at risk of malnutrition and pressure damage.

The premises had been designed with people's dementia care needs in mind. For example, pictorial and written signage was displayed around the home to highlight toilets, dining areas and bedrooms to assist people with orientation.

Staff and people enjoyed good relationships and there was a positive atmosphere in the home. People were involved in the service and explanations were given to people by staff when they delivered care. Staff presented people with choices so that they lived their lives in the way that they wanted to. People were encouraged to be as independent as possible and they were treated with dignity and respect at all times. Care was person centred and care records reflected people's current needs and any risks that they were exposed to. These records were regularly reviewed, well maintained and securely stored.

People were supported and protected from the risks of social isolation as there was a wide variety of activities for them to pursue should they choose to both internally within the home and externally within the community.

People, their relatives and staff described an open culture within the home and we found a welcoming and homely atmosphere. Staff were accountable for their actions and understood the responsibilities they were given. The requirements of the provider's registration were met and we were satisfied that notifications of deaths and other incidents were made in line with the requirements of the Care Quality Commission (Registration) Regulations 2009. A number of audits were carried out including those related to medication, infection control and health and safety. Other checks and monitoring of the service delivered were carried out to identify any issues or shortfalls. Action plans were utilised as a tool through which to drive improvements and feedback was obtained from people, their relatives, staff and healthcare professionals linked with the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe living at Cramlington House. Safeguarding procedures were in place and staff were knowledgeable about safeguarding.

Staffing levels were appropriate to meet people's needs and recruitment processes were robust.

Medicines were managed safely, as were risks that people faced in their daily lives and environmental risks within the home.

Is the service effective?

Good

The service was effective.

People received care that supported and met their needs. The environment of the home supported people with their dementia needs.

People's nutritional needs were met and where necessary input was sought into people's care if they needed support from, for example a dietician or speech and language therapist.

The MCA was applied appropriately and people's consent was sought before care was delivered.

Staff were supported to develop and maintain their skills through regular training, supervision and appraisal.

Is the service caring?

Good

The service was caring.

Staff and people enjoyed good, positive relationships. Staff treated people with dignity and respect.

People were encouraged to be as independent as possible.

People and their relatives were involved in the service.

Independent advocates could be arranged for people should they require this type of support.

Is the service responsive?

Good

The service was responsive.

Staff provided person-centred care in line with people's individual needs. Care records were detailed, relevant, and well maintained.

People were offered choices in all aspects of their daily lives and their choices were respected.

There was a wide range of activities on offer for people to pursue, both internally within the home and externally within the local community.

Complaints were handled appropriately and feedback was obtained from people, their relatives, staff and healthcare professionals linked to the home on a regular basis.

Is the service well-led?

Good

The service was well led.

The service promoted an open culture and staff morale was good.

Staff were accountable for their actions and recognised their responsibilities.

The service used auditing and checking systems to ensure the quality of the service delivered was good. Records were stored securely.

The service had good community links through partnership working and the pursuit of activities.

Cramlington House

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 20 June 2016 and was unannounced. The inspection was carried out by one inspector.

A provider information return (PIR) was not requested before this inspection. A PIR asks the provider for information about the service and any improvements that they plan to make. Prior to this inspection we reviewed all of the information that we held about the service including any statutory notifications that the provider had sent us and any safeguarding information received within the last 12 months. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are reports of deaths and other incidents that have occurred within the service. In addition, we contacted Northumberland Safeguarding Adult's team, Northumberland Local Authority Contracts and Commissioning team and Healthwatch. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. We used the information that these parties provided to inform the planning of our inspection.

As part of our inspection we spoke with ten people, five people's relatives, eight members of the care staff team, kitchen staff, the deputy manager, the registered manager and the operations manager. We also spoke with two healthcare professionals who visited the home during our inspection. We reviewed a range of records related to people's care and the management of the service. These included looking at five people's care records, five staff files, and other records related to quality assurance and the operation of the service such as audits and meeting minutes.

Good

Is the service safe?

Our findings

At our last inspection we identified shortfalls related to the management of medicines. At this visit we found improvements had been made in this area. People told us they received the medicines they needed safely. We observed the administration of medicines during our visit and found staff carried out this process safely. Medicines administration records (MARs) were well maintained and reflected that the recording of the administration of medicines was in line with best practice guidance. Personalised plans were in place for the administration of 'as required' medicines detailing when these should be given to those individuals who required them, for example, when they displayed identified signs of being in pain. All of the medicines we checked were within their expiry date and stored in line with manufacturers guidelines. Systems were in place to account for and dispose safely of medicines that were no longer required. Controlled drugs, which have the potential for abusive use or dependency, were stored appropriately and a detailed and appropriate register of stocks was maintained. We carried out a random check of these medicines and found that remaining stocks balanced with the register. The application of topical medicines applied to the surface of the skin, such as creams, ointments and lotions, was well managed. Those people who required such medicine had a detailed body map in place detailing the medicine, where it should be applied, and how often. Topical medicine administration charts were also in use which staff signed to confirm when such medicines had been applied. This provided accountability for staff.

People told us they were happy living at Cramlington House and they felt safe in the building and in the presence of the staff who cared for them. Comments people made included, "I do feel safe here", "I am happy here" and "The staff have always been nice". Relatives told us they held the service and staff in high regard and confirmed that they had not witnessed any practices within the home that had concerned them when they visited.

We observed staff delivered care that was both appropriate and safe. For example, staff supported people to move around the home safely either with walking aids or without, depending on their dependencies and abilities. Staff also ensured that people's medicines were administered in line with best practice guidelines.

The provider had detailed safeguarding and whistleblowing policies and procedures in place that provided staff with the guidance they needed to escalate any concerns of a safeguarding nature, should they arise. Staff had received training in the safeguarding of vulnerable adults and were aware of their own personal responsibility to report matters of a safeguarding nature. They displayed a knowledge of the different types of abuse that people could potentially be exposed to and were aware of the internal and external channels through which they should report any incidents of harm or abuse, in order to safeguard the vulnerable people they cared for. The registered manager retained detailed records about any on-going or historic safeguarding matters and these records showed she worked well with the local authority safeguarding team to progress and conclude investigations. The registered manager kept the Commission informed of safeguarding incidents that occurred within the home.

Staffing levels within the home were appropriate to people's needs on the days that we visited the home. Staff were alerted to any call bells that were activated and responded to them promptly checking if fellow

staff needed assistance. The home was split into three separate units and the service delivered in each area was always overseen by either a unit manager or senior carer, who was supported by a number of carers. In a more senior position above the unit managers was a floor manager, the deputy manager and then the registered manager. Staff told us that the number of staff on duty was sufficient to meet people's needs and they got support from the management structure above them. The registered manager said relatives had complained recently about a lack of staff on one particular unit and so the provider had increased staffing levels on the unit by one carer. Staff said this had assisted them and they appreciated the extra member of staff so that they could provide a better service to people.

Evidence in staff files demonstrated that the provider's recruitment and vetting procedures of new staff were appropriate and protected the safety of people who lived at the home. Application forms were completed including previous employment history, staff were interviewed, their identification was checked, references were sought from previous employers and Disclosure and Barring Service (DBS) checks were obtained before staff began work. DBS checks help providers make safer recruitment decisions as they check people against a list of individuals barred from working with vulnerable adults and children. The registered manager told us she had adopted a change in the recruitment process recently whereby prospective new staff were interviewed twice and during their second interview they spent time sitting and engaging with people, and observing staff practice. This meant potential new staff were more fully informed about the role that they were applying for and it also allowed the manager to see how they interacted with people. The manager told us this was to prevent a high turnover of staff, to ensure that the right staff were selected and also to ensure that staff applying for the post were aware of the varying dementia care needs of the people who lived at the home. Matters of a disciplinary nature were dealt with appropriately and records showed that full investigations were undertaken when necessary. This demonstrated the provider had systems in place designed to ensure that people's health and welfare needs were met by staff who were of good character and who had the appropriate competence and skills to carry out their jobs.

Accidents and incidents that occurred within the home were appropriately managed and analysed to ensure that people remained safe. Preventative measures that could be introduced were, and medical attention was sought where needed. The registered manager told us, and records confirmed that on a monthly basis she carried out an analysis of accidents and incidents that had occurred, to identify if any trends or patterns had emerged that needed to be addressed. She also advised us that if people fell more than three times a full review of the issues and actions taken in response to each individual event was carried out, with a view to referring people on to their GP for external input into their care from, for example, the specialist falls team.

Risks that people were exposed to in their daily lives had been assessed and measures put in place to safely manage and mitigate against these risks. For example, some people had risk assessments in place related to their tendency to have a low fluid intake and others related to the risks of falling. There was detailed information about the steps staff should take when delivering care to reduce these risks as much as possible. Records showed that risk assessments were regularly reviewed to ensure their content remained current, in line with people's changing needs.

Environmental risks around the building had been assessed and these were reviewed on a regular basis. Regular fire and health and safety checks were carried out and documented. Equipment, including the lift, was serviced and maintained regularly in line with manufacturers' recommendations. Checks were carried out on electrical equipment, the electrical installation within the building and utility supplies, to ensure they remained safe. We saw evidence that a legionella risk assessment had been carried out and control measures were in place to prevent the development of legionella bacteria, such as testing water temperatures regularly and decontaminating showerheads. This showed the provider sought to ensure the

health and safety of people, staff and visitors.

An 'Emergency File' was in place and easily accessible. This included information about the assistance each person would require should they need to be evacuated from the home in haste and a list of important contacts. A more detailed personal emergency evacuation plan (PEEP) was retained within each person's care records. The file also contained equipment for breaking glass, keys for the lift cupboard for emergency use and the lift emergency release procedure. A provider business continuity plan had been drafted which detailed the procedures staff should follow in the event of, for example, a flood or utility supply failure.

Good

Is the service effective?

Our findings

People gave us positive feedback about the care they received and whether it met their needs. One person said, "I can't see how better they could do it (deliver care)". Another person told us, "We are getting well cared for here". Relatives relayed positive feelings about the care delivered at the home also. One relative commented, "It is really good here", another relative said, "We have no complaints at all" and a third relative told us, "You couldn't get better care; it is care for everyone".

Our own observations of care being delivered throughout the home confirmed what people and their relatives had told us. We were satisfied that people received a good service and their needs were met in a timely manner. Staff were clear about people's needs and how to support them appropriately. When we asked staff about the needs and behaviours of particular individuals, they were able to explain these in detail to us and they clarified how they would support these people effectively. The information they gave us tallied with information held in these people's care records and our own observations.

People's general healthcare needs were met and we found evidence that people were supported to access routine medical support, or more specialist support such as that from a speech and language therapist, whenever this was necessary. Two visiting healthcare professionals shared with us their views of the care they saw delivered at the home. They told us, "The calls I get are appropriate, if anything they err on the side of caution"; "Instructions I have given have always been carried out"; and "I think people get well looked after here".

People's nutritional needs were met and managed well. Where necessary, food and fluid charts were used to monitor that people ate and drank in sufficient amounts to remain healthy. They detailed how much food or drink was offered, what it was, the size of the portion and how much was consumed. People were weighed weekly, to ensure that any significant fluctuations in their weight were identified promptly and investigated. Any weight losses and gains were clearly recorded and reported to senior care staff who were responsible for taking appropriate action to mitigate the risk of any weight changes. Adapted cutlery, plates and drinking aids were available where people needed support to maintain their independence when eating and drinking. People reported that they liked the food they were offered. One person commented, "The food, I like!" and another person told us, "The food is good; it is good enough for me". The chef told us they were kept informed by senior care staff or unit managers about people's dietary requirements and any changes in their needs. We saw that at lunch the chef was very aware of people's allergies and ensured that one person was not given a particular meal due to their allergy to a particular food group. A large whiteboard was maintained in the kitchen with details of people's likes, dislikes, allergies and any consistency requirements.

Staff, people and their relatives told us that communication within the service was good. All parties said they felt fully informed and there were communication tools in place to share messages amongst the staff team, such as regular handover meetings between changing staff teams. The newly established electronic care records system had a facility through which messages could be sent electronically to the staff team. Staff told us they were required to log into this system at the start of each shift and this meant that important messages were shared easily. Relatives told us they were contacted and kept up to date with any

developments or changes in their relations care. One relative commented, "Any changes about anything they (staff) tell me. They (staff) telephone me to tell me". One healthcare professional told us that at times the communication internally between senior care staff and unit managers was not good as they were asked to review issues they had already addressed and given instructions about. We discussed this with the registered manager who advised that she would look into this matter further.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Information in people's care records indicated consideration had been given to their capacity levels and their ability to make their own choices and decisions in respect of the MCA. Applications for Deprivation of Liberty Safeguards (DoLS) had been made to the local authority safeguarding team in accordance with good practice and the provider was awaiting the outcome of these applications. There was evidence the principles of the 'best interests' decision-making process had been followed in practice and records were retained about these decisions. 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms were in place where people had consented to these, and where they were unable to consent, a communal decision instigated by a clinician had been made. The registered manager told us some people had appointed their relatives as attorneys (through the office of public guardianship) to act on their behalf when decisions in respect of their health and wellbeing needed to be made. The provider had obtained copies of legal documentation confirming this for some people but not for others. The registered manager told us they would discuss this matter with people's relatives and ask that if applicable, they bring in copies of the relevant documents as soon as practicable, so the provider could be assured that people's relations had the legal authority to act as an attorney.

In all aspects of their daily lives people's consent was sought before staff delivered care. For example, we heard staff asking people if they would take their medicines before they were given to them and records showed that some people had refused at times to take them. This demonstrated that staff understood people's right to consent to care and they respected this right.

Records showed that staff received regular training via e-learning and face to face courses, which were relevant to their roles. Records showed training requirements were monitored via an electronic staff database and arrangements were made for training to be refreshed as and when required. This ensured that staff were supported to deliver effective care as their skills were kept up to date. Staff had completed training in a number of key areas such as safeguarding and first aid, as well as some specialised training relevant to their roles, including Non Abusive Psychological and Physical Intervention (NAPPI) training, dementia care and skin care. An induction programme was in place and completed by new members of staff at the point they commenced employment with the service. A newer member of staff told us they found the induction programme to be in depth and it had prepared them for their role. They said, "The induction I had was really in-depth and you shadow staff which is good. The support I have received so far has been really good. Everyone is great".

Staff told us, and records confirmed that supervisions took place regularly and appraisals annually. All of the

staff we spoke with said they found these one to one sessions with their manager useful and supportive. Supervisions and appraisals are important as they are a two-way feedback tool through which the manager and individual staff can discuss work related issues, training needs and personal matters if necessary.

The environment of the home was clean, tidy, spacious and well maintained. There were adequate facilities such as communal areas, bathrooms and toilets for people to access. Consideration had been given to the environment so that people were appropriately supported in line with their cognitive impairments. For example, there were brightly coloured toilet seats and toilet brushes to aid people to use the toilet independently. Walls were painted different colours where there was a change in direction, and pictorial and written signage was in place to orientate people, for example, to the dining room or toilets. The provider had invested in a coffee shop, hairdressing salon and cinema room when designing and building the home, and this provided people with stimulation to occupy their minds. People also had unlimited access to outdoor space at their leisure, in the form of an enclosed patio garden area. They were supported to move in and out of this area independently through doorways with brightly coloured edging around the frames.

Good

Is the service caring?

Our findings

People and staff enjoyed good relationships. The service had a calm, positive atmosphere and this was reflected in the feedback given to us by people and their relatives who were all very happy with the service they received and the relationships they had established with the staff team. One person told us, "The staff are very good" and another person said, "Ah, the staff are really canny (nice)". Relatives shared with us their thoughts about the staff at the home. They referred to them as "really good" and "superb". One relative commented, "The staff need praising they really do. They are just such lovely caring professional people".

One relative told us that staff knew people really well and displayed very caring attitudes. They told us about a time when they had noticed the little caring touches staff had displayed when they put sun cream, hats and anti-glare glasses on their family member when they were sitting outside in nice sunny weather one day. We noticed caring touches ourselves during our inspection. One lady said at lunch, "I am a bit cold". A staff member responded immediately and said, "Let me go and get your cardigan straight away". They returned and placed the cardigan gently around the person's shoulders whilst they continued to eat their lunch. We observed staff throughout the day supporting people gently by placing a guiding hand on their backs, or offering an arm for support. One person knocked over a glass at lunch and apologised to a member of staff nearby who reassured them instantly and said, "It's alright; no problem at all". When people were assisted by staff they thanked them and staff replied by saying "you are welcome". Staff asked people how they were, whether they had enjoyed their food or an activity and they spoke with them about their lives and past times. The relationships and interactions we saw during our inspection had a positive impact on people's wellbeing.

Staff were motivated and reflected pride in their work. They talked about people in a way which demonstrated they wanted to support them as much as possible and provide a high standard of care. Staff interactions with people were always respectful, pleasant and polite. People were treated with dignity and respect and staff described to us how they ensured they treated people in this way. For example, we saw staff knocking on people's bedroom doors before being invited to enter, so that their privacy was respected. Conversations about people and their care needs were held discreetly by staff and this ensured that their dignity was protected.

People were encouraged to be as independent as possible and they responded to this. One person told us, "I am an independent person and they (staff) definitely encourage it". One person needed assistance to rise from their chair and said to staff, "Right I am going to do this; I am standing up". Staff prepared the person for their manoeuver explaining what needed to happen for this to be done as independently and successfully as possible. The person was able to push up from the chair themselves with only a guiding hand from staff on either side of their body. People were also able to eat independently and with dignity because they were provided with adapted cutlery and plates to prevent spillage and mess, and if they wished, a clothes protector was available to keep their clothing clean. People were provided with equipment which enabled them to move around the home independently such as tri-walkers, walking frames and handrails in communal areas for support. This showed the service promoted people's independence and supported them to do as much as they could for themselves, providing explanations where needed.

People were at the heart of the service and they were involved in how it was run, as were their relatives. 'Resident and Relatives' meetings were held regularly and minutes from these meetings showed that people and their relatives were asked for their opinions and feedback about key areas of the service such as the food served and activities on offer. Relatives told us they felt involved in their family member's care and they felt they were kept informed about any changes in their health and wellbeing in a timely manner. The home had recently introduced some pet rabbits into the outdoor area on one unit and we saw that people and relatives were consulted about the new additions in their 'Residents and Relatives' meeting. People and staff talked about the recent birth of baby rabbits within the home, whom we had the pleasure of meeting during our visit. People talked positively about how they enjoyed engaging with the rabbits regularly and were eager to tell us about the babies born days earlier. Staff told us people assisted in caring for the rabbits, but only if they wanted to.

The registered manager told us church services were held in the home on Sundays and clergymen visited people individually if they requested this in line with their religious needs. The registered manager told us people had individualised needs but no people currently living at the service had a diverse cultural need.

Independent advocacy services could be arranged for people if they so wished. The registered manager told us that most people's relatives acted as their advocates and that no person living at the home at the time of our inspection had an independent advocate in place supporting them with their decision making.

Good

Is the service responsive?

Our findings

People told us the staff team and management were responsive to their needs, any requests they made for assistance and any issues that they raised. One person told us, "I have got nothing to moan about. The staff are alright and they do the best they can for me". Another person said, "They have helped me with everything I have needed so far". One relative commented, "We have no complaints" and another said, "Staff know the residents; they are people-focused". One relative described to us how their mum loved to draw and how staff had bought a colouring book for them to complete. They said, "It was lovely that they sought that out for her". This is an example of how staff delivered person centred care.

Staff described how they cared for individual people in respect of their differing needs and behaviours. We observed staff responded to one person when they displayed a particular behaviour towards another person in a communal lounge, on the afternoon of one of our inspections. Staff were very professional and discreet in how they dealt with this situation, which became calm once they interjected. They were calming and reassuring to both people involved. People were provided with food in line with their preferences and any allergies were clearly recorded in the kitchen area so that people were not provided with food types that may put them at risk.

People were offered choices throughout our inspection. We saw people being offered different types drinks, snacks, activities and choices about what they did. One person refused to eat their lunch in the dining area and so their food was brought to them on a table in the corridor area where they were happily seated. Other people were able to eat their food in their rooms. In line with people's dementia needs, when two food options were brought to the dining room for lunch, a member of staff went around each person with two different plated meals for them to see and choose at the point of it being served. People were invited to partake in activities that were on offer during the day, but where they declined, peoples' choices were respected and there was no pressure for them to join in.

There was a wide range of activities on offer to stimulate and motivate people. An activities co-ordinator was employed Monday to Friday from 10am to 6pm and they also provided activities for staff to support people with during the weekend. There were three activities rooms in the building, one in each unit, and these contained cooking areas and equipment for activities such as baking to be pursued. In addition, there were tables and chairs for crafts to be done. There was also a knitting club within the home which some ladies told us they enjoyed attending. Within the home itself there was a café, cinema room and a hairdressing salon. Outdoor garden areas housed pots and plants that people were supported to tend to and cultivate by staff. The registered manager told us that each summer season the provider hired a beach hut at nearby Blyth beach from June to August, whereby a small number of people were taken by minibus one day during each week, to enjoy a day out and fish and chips at the coast. The registered manager also told us that a small group of people went weekly or fortnightly to a local group called 'Mind Active'. This group is a charitable organisation whose slogan is 'Promoting Inclusion through Mental Stimulation'. They quote their aim as seeking to compliment and build on activities available within residential homes and to enable people living with dementia in their own homes to continue as part of the community.

The registered manager also told us that people visited the Alzheimer's Society in the local community, visited the local shopping centre to raise funds for activities through running a tombola stall and in June a sponsored walk in the local area raised hundreds of pounds for future entertainment and activities. People, relatives and staff told us that weekly on Friday afternoons a local ice cream seller visited the home and people could buy an ice cream if they wished. The above activities being made available to people showed the provider promoted community involvement, social inclusion, and they considered and supported people's mental well-being.

Since our last inspection the provider had introduced an electronic care records system to the home where people's personal information, care records, risk assessments, reviews, daily notes and any other pertinent information was retained and updated. Within the system there was an email alert facility which enabled the management and senior care team to send messages and highlight important information to staff. This was brought to staffs' attention when they logged onto the system at the start of each shift as they could be marked as high priority and unread until they were opened. Staff and management told us this had improved communication amongst the staff team. There was also a tablet available in each unit linked to the electronic system, that was transported around by care workers to more easily record and input daily events, interventions, monitoring and incidents when they occurred. Staff and management told us this had resulted in better record keeping.

We reviewed a number of different people's care records and found these to be person-centred, detailed and covering a range of needs. For example, people had care plans in place where they had a mobility need, behaviour issues and medication needs. Care monitoring tools in the form of food and fluid intake, continence and behaviours/mood monitoring were also inputted onto the electronic system, which had the capability of displaying trends visually in graph form, for analysis and action to be taken. Pre admission assessments, on-going dependency assessments and analysis of people's needs were completed regularly and maintained within the system. Best interest decision making and capacity assessments were also documented within the electronic records. Access to all of this information was made easier for staff due to the nature of the electronic access points on each unit and in the management offices. In addition to the electronic records, daily handover sheets, a diary, weight monitoring and certain medicines information was retained in written format on each unit, to ensure that this information was readily available and could be discussed communally at daily handover meetings. This showed the provider had systems in place to support continuity of care as much as possible.

People and their relatives told us they were fully aware of the complaints procedure within the service but all said they had not had a reason to raise a formal complaint to date. One person commented, "There is nothing that I am not happy with but I would soon shout if I was". A relative told us, "I have had nothing to complain about. X (relative) being here has taken a weight off my mind". The complaints policy was brought to people's attention in information packs they were issued with when they started using the service and minutes of 'Relatives and Residents' meetings showed people and their relatives were directed to this policy should they be dissatisfied with any aspect of the service. A log of any complaints received was maintained in the registered manager's office. We saw that seven complaints had been received in 2016 to date and records showed these complaints had been handled appropriately and all relevant parties informed at each stage. The paperwork related to each complaint and its resulting investigation had been retained.

The provider had systems in place to gather feedback from people, their relatives, staff and outside agencies. For example, 'Residents and Relatives' meetings were held within the home and also a variety of staff meetings. Staff also had the opportunity to feedback their views and concerns during supervision sessions or at any other time. Annual surveys and questionnaires were sent out to staff and professionals linked to the service. We studied the results of these surveys and questionnaires and saw that the feedback

received was positive. Statements made included, "I have never had less than 100% confidence in the quality of care", "The care staff are extremely friendly, so are all the other staff on the floor (laundry, kitchen, cleaners etc)", "The staff are excellent" and "Whenever there is a problem the home contacts us immediately to discuss and resolve any problems if it is major". Records showed an analysis of these results was carried out and we saw that action plans were created to address any issues raised. This showed the provider had channels through which they could gather feedback from people, their relatives, staff and professionals working with the service, in order to respond where changes and improvements were needed.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post who had been registered to manage the carrying on of the regulated activity at the service since August 2014. The registration requirements of the service had been met and we were satisfied that incidents had been reported to us in line with the requirements of the Care Quality Commission (Registration) Regulations 2009.

People, their relatives, staff and healthcare professionals gave positive feedback about the leadership of the service saying they could approach senior management at any time about anything. One person told us, "I have never had any reason to complain. They seem to run it well here" and another person told us, "The manager is nice here". Staff said they felt supported by management. One member of staff commented, "The leadership is great. If there is not one senior person available then there is another". A visiting healthcare professional described their relationship with the registered manager and said, "I feel the leadership has been really positive, very proactive. They have been thankful for us getting involved". Another healthcare professional said there was no problem with their relationship with the registered manager or operations manager and a third visiting healthcare professional told us, "It is extremely organised. When I go into the home, they have their list of who needs to see me and they bring people to me. It is always a pleasure to go – it's a lovely place".

The service had a structured management team in place, with the provider being supported by an operations manager who oversaw operational matters at this service and another of the provider's services nearby. Underneath the operations manager there was the registered manager who was supported by a deputy manager, floor manager, and then senior carers/unit managers and care workers on each of the three separate units within the home. The registered manager told us that the provider visited the service approximately twice a week and was fully involved in the service. All of the staff team including the registered manager confirmed the structure and levels of support within the service were very good.

Staff meetings at a variety of different levels took place regularly and minutes showed the registered manager kept staff informed about important matters and changes to the service. The provider also used these meetings to deliver messages to the staff team. A daily handover meeting took place between senior carers or unit managers on duty on each unit, the deputy manager, floor manager and registered manager each morning. This ensured that senior staff were kept up to date with any changes and important information in a timely manner. The new electronic care records system also supported good communication and it gave accountability as entries made in the system, or those not made when they should have, could be traced by staff member log ins. The registered manager and operations manager told us this added accountability had improved staff record keeping within the service. People's personal care records and information was stored securely electronically and where paper records were in use, these were also confidentially stored in the paperwork stations in each individual unit, or in the registered manager's office.

Quality monitoring systems were in place to ensure that the service delivered was effective and issues were identified and improved where necessary. For example, in terms of staff practice, medication competency

assessments were carried out and 'Dining Experience' assessments had been introduced recently to monitor staff performance in terms of the service delivered and whether people were treated with dignity and respect. Staff performance was also assessed and monitored through regular supervision sessions and annual appraisals.

A range of different audits and checks were carried out to monitor care delivery and other elements of the service. These included for example, monthly infection controls audits, medication audits, safeguarding incident monitoring and behavioural monitoring. Analysis of accidents and incidents that had occurred, were completed regularly. Health and safety audits/checks around the building were also carried out regularly. There was evidence that where issues were identified, action plans were created and steps had been taken to ensure matters were addressed. The registered manager also used a range of matrices to monitor progress with, for example, staff training and DoLS applications and expiry dates. This showed that systems were in place to monitor the service delivered and to address any shortfalls and drive improvements, should this be necessary.

On a weekly basis the registered manager was responsible for sending a report to the operations manager to inform them about any issues that had occurred within the service that week. This included any important communications, accidents, incidents, health and safety issues, complaints or concerns received, staff issues and other matters of interest. The operations manager visited the home regularly and in addition carried out a monthly audit which included making general observations of the service delivered and the environment, reviewing paperwork, record keeping and personnel files, amongst other things. Where the operations manager identified areas for development these were noted at the end of the audit for the registered manager to follow up. Feedback about the service was also gathered through staff, resident and relative questionnaires and surveys for external healthcare professionals linked to the service. This showed senior management had an overview of the service and regularly monitored its effectiveness.

The provider had recently introduced a quarterly newsletter which introduced a different staff member each time, reported on recent events within the home, activities, people's birthdays and any other important local information. An 'Employee of the year' initiative had also been introduced since our last inspection whereby staff were assessed against a set criteria in terms of their contributions to the service, taking into account their sickness levels, training completed, any compliments received and any examples where they had gone 'above and beyond' their duties within their roles. Last year three staff were recognised as meeting these criteria A 'Feel good Friday' initiative was also in place where management bought cakes and pastries on a Friday for staff to enjoy in the staff room. Staff told us they felt valued and morale within the home was good.

The service had good links with the community locally and the operations manager had recently worked with the manager of a local shopping centre, at their request, to provide basic training to the shopping centre staff about the needs of people living with dementia. The service also had many community links through the variety of different activities they offered to people living at the home, within the local area.