Parkside Care Limited

Northlands Care Home (Northumberland)

Inspection report

Northlands Nursing Home
21 Kings Avenue
Morpeth
Northumberland
NE61 1HX

Tel: 01670512485

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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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This was an unannounced inspection which took place on 19 July 2018. This meant the staff and provider did not know we would be visiting.

This was the first inspection of the service since it had re-registered because of a change of provider in March 2017.

Northlands is a care home. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Northlands accommodates a maximum of 35 people who require nursing care or personal care, some whom may live with dementia or a dementia related condition. At the time of inspection 32 people were accommodated at Northlands Care Home.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People, relatives and staff were very positive about the changes that were taking place to make improvements since the change of ownership of the home. They told us the new providers were very friendly and approachable.

People said they felt safe and they could speak to staff as they were approachable. We considered that staffing levels needed to be reviewed and that staff were appropriately deployed to meet people's needs in a safe, timely and person-centred way.

Improvements had been made to activities and entertainment but we considered people should have opportunities for stimulation and engagement with staff. Care staff were not always able to take the time required to interact and take an interest in people's hobbies and activities. Staffing levels meant care was sometimes task-focussed.

The home was being refurbished. However, not all areas of the home were clean and well-maintained for the comfort and safety of people who used the service.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Risk assessments were in place and they identified current risks to the person. Records were in place that reflected people's care and support requirements and they were regularly reviewed to ensure they remained accurate. Staff knew the people they were supporting well.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. Systems were in place for people to receive their medicines in a safe way. However, we have made a recommendation about the management of medicines as records were not in place to demonstrate that people who received medicines covertly (without their knowledge) had this decision taken in their best interests.

Appropriate training was provided and staff were supervised and supported. Staff had an understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice. Improvements were required to the documentation to evidence some best interests decision making.

Care was provided with kindness and compassion and people's dignity was respected. However, improvements were required to people's dining experience.

Menus needed to ensure people received a varied and balanced diet to meet their nutritional needs. We have made a recommendation about this.

The home had a quality assurance programme to check the quality of care provided. However, the systems used to assess the quality of the service had not identified the issues that we found during the inspection with regard to staffing levels, medicines management, people's dining experience, environment and best interest decision making.

A complaints procedure was available. Staff and relatives said the management team were approachable. People had the opportunity to give their views about the service. There was consultation with people and family members and their views were used to improve the service. People had access to an advocate if required.

During this inspection we found a breach of Regulations 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we 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

Not all aspects of the service were safe.

Staffing levels and staff deployment required review to ensure people received safe and effective care. People were protected from abuse as staff had received training with regard to safeguarding. Appropriate checks were carried out before staff began working with people.

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

Risk assessments were up to date and identified current risks to people's health and safety.

People received their medicines in a safe way. However, where people received their medicine covertly (without their knowledge) correct processes had not been followed.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

People did not always receive a varied and balanced diet. Some improvements were required to the organisation of people's dining experience. Support was provided for people with specialist nutritional needs.

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

People's rights were not always protected. Best interest decisions were mostly made appropriately on behalf of people, when they were unable to make decisions about their care and treatment. However, they did not show the best interest decision making where restraint such as bed rails and lap straps were used to keep people safe.

Is the service caring?

Good

The service was caring.

Staff were caring and respectful. People and their relatives said the staff team were compassionate, kind and cheerful.

Regular staff were aware of people's backgrounds and personalities. Good relationships existed and staff met people's needs in a sensitive way that respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

There was a good standard of record keeping to ensure people's care and treatment needs were met.

Improvements had been made to activities and entertainment to keep people engaged and stimulated.

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

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

The registered manager and provider monitored the quality of the service provided and introduced improvements.

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

A registered manager was in place who encouraged an ethos of involvement amongst staff and people who used the service. Staff said they felt well supported and were aware of their rights and their responsibility to share any concerns about the care provided at the service.

Communication was effective to keep people and staff informed about the running of the home.

Northlands Care Home (Northumberland)

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 19 July 2018 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also contacted commissioners from the Local Authorities who contracted people's care and the local Healthwatch to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 10 people who lived at Northlands, six relatives, the registered manager, the deputy manager, one director of the organisation, the chef, one nurse, five support workers, the activities co-ordinator and two visiting care professionals. We looked in the kitchen. We reviewed a range

of records about people's care and how the home was managed. We looked at care records for five people, recruitment, training and induction records for four staff, five people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Requires Improvement

Is the service safe?

Our findings

People told us they were safe living at the home. One person said, "I feel quite safe. All the staff are very good especially the carers." Another person commented, "I think there are enough staff. They come almost immediately when they are called." A third person told us, "I think it is safe wherever you go in the home." Other people's comments included, "I trust the staff", "The staff are dedicated", "I think there are enough staff" and "Staff are always busy."

There were 32 people living at the home at the time of inspection. The registered manager told us 12 people on the top floor were supported by two support workers including a senior support worker and one nurse. On the middle floor and ground floor, which were combined as people from downstairs went upstairs during the day, 20 people were supported by three support workers, one apprentice worker and a nurse. Overnight staffing levels included three support workers and one nurse.

The registered manager told us a staffing tool was used to calculate the number of staffing hours required. Each person was assessed for their dependency in a number of daily activities of living. The dependency formula was then used to work out the required staffing numbers.

Our observations during the inspection showed, staffing levels needed to be reviewed to ensure sufficient staff were available and appropriately deployed to provide safe and effective care to people in all parts of the home. On the middle floor staff were rushed but tried to respond promptly and patiently to people's requests for support. One staff member told us, "We will answer a buzzer and tell a person we will come back to them because we are busy." People sitting in the lounges were left unattended during the day. CQC intervened on three occasions whilst sitting with people in the middle floor lounge to locate staff and alert them when people required some assistance, such as to go to the lavatory or wanting a drink, as not all people had the means or capacity to call staff when they required support.

We considered staffing levels and staff deployment should be reviewed across the home particularly to the middle floor as there was a high level of physical dependency with some people being nursed in bed. On the day of inspection we observed care was task-centred. On the middle floor staff were particularly busy due to people's needs. The only engagement with people was at mealtimes and when the drinks trolley came around or when people were assisted with personal care. We did not observe staff engage and interact with each person, reassuring them if they became upset and encouraging their awareness and interest in their surroundings. For most of the day some people sat sleeping in the lounges in front of a television and there was nothing of interest to keep them engaged and stimulated when staff were busy. Staff told us the morning routine was always busy and when they had time they would spend time with people in the afternoon. We did not observe this on the day of inspection as people sat on their own in the lounge in the morning and afternoon, when they did not want to join in organised outside afternoon activity.

From our observations improvements were needed to ensure that all staff interacted with people at all times, and not only when they carried out care and support with the person. When staff were busy other people had to wait and were left unsupervised. We were also informed people did not get the opportunity to

go out spontaneously into the local community as staffing levels did not permit this.

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

People's individual risk assessments were in place with a system of review to ensure they remained relevant, reduced risk and kept people safe. The risk assessments included risks specific to the person such as for moving and assisting, use of bed rails, choking, nutrition and pressure area care. We discussed with the visiting health care professional about the incidence of pressure area care currently and was told this had been addressed by the registered manager. Further training was being provided for staff to help them recognise warning signs such as reddened areas.

People were positive about the refurbishment that was taking place and the standards of hygiene in the home. One person told us, "The place is 100% clean." Several people, staff and relatives confirmed the positive changes that had taken place around the home. However, some more urgent action was required on the middle floor. There was a malodour of urine in the middle floor lounge and as the kitchen door was kept open because of the heat in the kitchen, the heat and cooking smells from the kitchen permeated the middle floor corridor. The carpet by the kitchen entrance was stained and showing signs of wear. The flooring in the kitchen was also showing signs of wear and tear and some tiles on the cooker plinth were damaged and a possible infection control hazard. We discussed this with the provider's representative and registered manager who told us the kitchen was due to be refurbished including the replacement of the existing commercial extractor fan in the kitchen.

Maintenance records showed that routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. Records also showed that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MARs) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines.

Guidance was available for staff that detailed when people may need 'when required' medicines, for example, for pain relief. Photographs were available on people's medicines records reducing the risk of mistaken identity when medicines were administered by temporary staff.

Records showed that where people lacked mental capacity to be involved in their own decision making, the correct process had not always been used with regard to the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink). We saw 'best interest' decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as the best interest decision had not been made with all the relevant people. Documentation for one person recorded the GP and a family member had agreed the decision for the use of covert medicines. However, this did not include evidence of written feedback from parties relevant to a best interest decision such as the pharmacist, family members and care home staff. It is important for the pharmacist to be consulted when medicine is given covertly to

take into account any safety considerations.

We recommend the registered manager considers the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

Medicines were stored securely within the medicines trollies and treatment rooms. Medicines which required cool storage were kept in a fridge within the locked treatment rooms. A system was in place to record and monitor fridge temperatures daily to ensure refrigerated medicines were kept at a suitable temperature. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

Staff had undertaken safeguarding training about how to recognise and respond to any concerns. Staff we spoke with could describe the appropriate steps they would take if they were worried about people's safety or wellbeing. One staff member said, "I would report any concerns to a nurse or the manager." Safeguarding records showed prompt referrals had been made to the local authority safeguarding team, and investigations had been undertaken where necessary.

Regular analysis of incidents and accidents took place. The deputy manager told us accidents and incidents were monitored. Individual incidents were analysed and a regular analysis took place to look for any trends. They told us learning was identified from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to falls.

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

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

Requires Improvement

Is the service effective?

Our findings

Refurbishment of the home was taking place since the change of ownership in March 2017. Lighting had been replaced, windows had been double glazed, the nurse call system had been replaced, an outdoor terrace with non-slip decking, which overlooked the garden had been built with access from the middle floor. Bedrooms were being re-decorated with new flooring and bedding provided. One person told us, "The rooms are very comfortable and I have my own computer in my bedroom." Another person said, "I chose the colours for my room and I had a telephone put in in my room."

The environment was enabling to promote people's independence and involvement. Appropriate signage was in place around the home for people to identify the room and to help maintain their independence. Pictures and signs for people to identify their bedroom were in place to help maintain their independence. There were displays and themed areas of interest on corridors and walls around the home. Notice boards contained a lot of information and advertised activities in pictorial and written format. However, we advised the registered manager accessible information such as activities and menus should be advertised in a prominent place so people were reminded and aware of what was happening each day. The registered manager told us that this would be addressed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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. We considered the registered manager was working within the principles of the MCA with regard to DolS. They were applied for appropriately. However, improvements were required where people were restrained to keep them safe due to the use of bed rails or lap straps on seats. Records were not signed and did not show the best interest decision making with relevant people when the person did not have mental capacity to consent. We discussed this with the registered manager who told us it would be addressed.

The chef told us people's dietary requirements such as if they were vegetarian, vegan or required a culturally specific diet were checked before admission to ensure they were catered for appropriately. The chef told us menus were being reviewed. We considered this was necessary as there was no evidence of seasonal variation in the menus. For example, on the day of inspection, which was a very warm day, the lunch was curry or casserole and jam roly poly and custard. The four week menus did not show variation and healthy eating options. In week one chips were offered five times over the week and twice in one day. Several of the

meals were pie, chips, dumplings, cobblers and steam puddings and custard. Soup or sandwiches were served as an option for the tea time meal five nights of the week and sandwiches were also served at supper time each night. People's comments confirmed this. One person told us, "The food is very good." Another person commented, "The food is alright but there is not much variety." A third person said, "The food is okay but it is monotonous." We heard at tea time, one person commented, "I would love to have some cheese." We observed staff addressed this. People's comments from a provider survey included, "We need more choice on the menu, a steak night would be nice" and "It would be good to have a meeting with the cook once in a while to discuss our likes and dislikes and menus." We saw evidence that people's comments had been actioned. For example, themed dining events such as whisky and haggis and country and western style food had taken place. Resident and relative meetings also asked people about food suggestions.

We recommend menus are revised in accordance with dietician advice and taking into account seasonal variations.

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up-to-date and showed people with nursing needs were routinely assessed against the risk of poor nutrition using a recognised nutritional screening tool. One relative confirmed, "[Name] has put on weight since they have come here."

We observed the lunch time meal in the dining rooms. People enjoyed a mostly positive dining experience at the meal time, the atmosphere was calm in dining rooms. People ordered their food choices the day before. This process could be refined in case people forgot what they had ordered or did not want the meal when it was served. We intervened for a person who was served a meal they did not want. Menus were not available that advertised and kept people informed of the daily food choices. People were served in the dining room, lounges or their bedrooms and staff were available to provide full assistance to people, they were not always available in dining rooms where people required encouragement or prompting, as they were busy elsewhere. We heard staff ask people for permission before supporting them, for example with assisting them to the dining table or offering them protective clothing at the meal. We observed on the middle floor staff did not always speak to people or explain what the meal was as they served them. We discussed with the registered manager our observations where improvements could be made. They told us these would be addressed. Hot and cold drinks were served. People sat at tables that were set with tablecloths, napkins and condiments.

Staff members were able to describe their role and responsibilities. A number of staff members had worked at the home for several years. Newer staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work.

Staff had opportunities for training to understand people's care and support needs. A staff member commented, "We get plenty of training." Another staff member told us, "We do on-line and external training." A third staff member told us, "I have done safeguarding training with the local authority." A staff training matrix showed that courses took place to ensure staff had the knowledge to meet people's care and treatment needs. Staff training courses included dementia care, pressure area care, falls awareness, fluids and nutrition, syringe driver, equality and diversity, distressed behaviours, personal care awareness, palliative care, mental capacity and deprivation of liberty safeguards.

People's needs were assessed before they started to use the service. This ensured that staff could meet their

needs and the service had the necessary equipment for their safety and comfort. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives.

People and relatives praised the effective care provided, in terms of their health or family members' health and well-being. One person told us, "There is no doubt about it, if I'm unwell I am looked after." A relative stated, "[Name] is looked after very well." People's care records showed they had regular input from a range of health professionals. A visiting health care professional commented, "The staff know all their residents well. They involve the GPs when they need to."

Staff confirmed they had the equipment they needed to do their job safely. One staff member told us, "We have the equipment we need now. We just ask and we can get it instead of having to phone around to borrow it." Another staff member commented, "We have more equipment than we had, we have slings and equipment we need for hoisting people when they need moving and positioning help."

Good

Is the service caring?

Our findings

During the inspection there was a pleasant atmosphere in the home. People appeared calm and relaxed as they were supported by staff. Staff appeared to have a good relationship with people. People and relatives we spoke with all said staff were kind, caring and patient. One person told us, "Staff are so kind." Another person commented, "I can talk with staff if I am upset." Other people's comments included, "The staff are wonderful", "The staff are brilliant", "Staff do listen", "I can ask the staff for anything I need", "Staff go the extra mile." A relative told us, "There are no problems with the care. It is all very positive." Another relative commented, "The care is excellent here."

People were supported by staff who were warm, kind, caring and respectful. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging.

Information was available about people's likes, dislikes and preferred routines. Pen pictures were available in people's wardrobes in their bedrooms. However, this information was not available in the care records which were looked at by staff. We discussed this with the registered manager that this information should also be available in care records, they told us it would be addressed.

Written information was available that showed people of importance in a person's life. Relatives were involved in discussions about their family member's care and support needs and they could approach staff at any time. A relative commented, "Staff keep us informed about how [Name] is." Another relative commented, "Staff will phone me and let me know what is happening with [Name] and how they have been."

People who were able to express their views told us they made their own choices over their daily lifestyle. They told us they were able to decide for example, what to eat, when to get up and go to bed and what they might like to do. One person told us, "I do what suits me." Another person said, "I get up when I want."

People who lived with dementia were encouraged to make a choice and be involved in decision making. For example, with regard to meals, drinks and other activities of daily living. Staff we spoke with had a good knowledge of the people they supported. Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff told us they also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

People's privacy and dignity were respected. People told us staff were respectful. We observed that people looked clean, tidy and well presented. Staff knocked on people's doors before entering their rooms, including those who had open doors. Bedroom doors were closed when staff assisted people in their bedroom to protect their dignity. Records were held securely and policies were available for staff to make

them aware of the need to handle information confidentially.

The registered manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Good

Is the service responsive?

Our findings

There was a good standard of record keeping to help ensure people's needs were met individually. One visiting professional told us, "Care records are well-organised, I can find the information I need. I wish more places were like this."

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

Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. Care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. We were told this was discussed and the relevant people were involved in the decision making to inform staff of the person's wishes at this important time.

People knew how to complain. People we spoke with said they had no complaints. The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and a complaints procedure was in place to ensure they were appropriately investigated. Several compliments and cards of appreciation were available from people and relatives thanking staff for the care provided.

An activities organiser was employed. The registered manager told us their hours had been increased to 25 hours a week over four days. The provider survey showed that in response to people's comments activity provision had improved. However, we considered further improvements were required which could be addressed with the review of staffing hours to ensure staff had the opportunity to engage with people and carry out activities.

A programme of activities was available that advertised balloon exercises, sing-a-long, a visiting dog, one-to-one activities and visiting chaplain. People told us about the entertainment and organised activities that took place regularly. One person said, "I enjoyed the birds of prey." The registered manager told us about

the miniature zoo that was visiting in August, the alpacas and lambs that had also visited. 'Mind Active', a locally funded initiative also provided monthly sessions of activities into the home. Other entertainment included slides and music shows, singers and a visit to a tea-dance. A photography exhibition by local people had also taken place in the home and exhibits were displayed on the walls. Some people had visited Beamish Museum and outings were planned to an organised party in the park and picnics. The activities organiser had many ideas for activities and ways to keep people engaged and stimulated, if they wished to be involved. For example, doll therapy, puppets, picture bingo, dominoes, quizzes, darts and board games. We observed in the afternoon an activity took place with people on the terrace if they wished to go outside.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager who had re-registered with the Care Quality Commission as manager for Northlands Care Home in March 2017, when the home changed ownership. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

The registered manager assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The registered manager and provider's representative were able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

All people spoken with were very positive about the changes that were taking place since the change of ownership. One visiting professional commented, "Improvements have been made." Staff comments included, "The home has really improved since the new owners took over", "It is an amazing place and getting better all the time" and "There are loads of changes happening in the building."

The atmosphere in the home was welcoming and friendly. Relatives said they were always made welcome. Staff, people and relatives said they felt well-supported. One person told us, "The manager is approachable." A visiting professional commented, "If there are any issues we try and get them resolved straight away." Staff members comments included, "The manager is quite approachable", "Staff morale has improved", "I do feel valued" and "We do get opportunities to comment about the home." Staff commented they worked as a team and we observed they knew what they doing as they supported people.

People and their relatives were kept involved and consulted about the running of the service. Quarterly meetings took place with relatives and people who used the service and minutes were available for people who were unable to attend.

Staff told us and meeting minutes showed staff meetings took place. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. One staff member commented, "We have meetings every three months, but more often if there is an issue." Another staff member commented, "We try to go to staff meetings but when we are on duty it is difficult but minutes are available."

Staff told us communication was effective to keep them up to date with people's changing needs and the running of the home. A handover session took place, between staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. One staff member told us, "Handovers take place in the morning and at night when staff change shift." Another member of staff commented, "If you come in for half a day you get a handover to let you know what's been happening." Another staff member said, "Communication is usually effective, sometimes if it is an agency staff member doing handover they might not mention everything."

A variety of information with regard to the running of the service was displayed to keep people informed and

aware and this included the complaints procedure, safeguarding, advocacy and forthcoming events.

Auditing and governance processes were in place to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. All audits showed the action that had been taken as a result of previous audits where deficits were identified. Daily checks took place for medicines management and home presentation. Weekly checks included for the nurse call system, fire checks and for the safe maintenance of the premises. Monthly audits included checks on staff training, medicines management, accidents and incidents, infection control, nutrition, skin integrity, falls and mobility, health and safety and accidents and incidents. Other audits included for health and safety and infection control. However, the audit and governance processes had failed to identify deficits we found in best interest decision making, staffing levels, the environment and people's dining experience. We discussed these deficits with the registered manager and provider's representative who told us they would be addressed.

Records showed monthly visits were carried out by the provider's representative who would speak to people and the staff regarding the standards in the home. They also inspected the premises and audited a sample of records such as care plans, accidents and incidents, maintenance records, risk assessments, medicines records, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

The provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people who used the service, relatives and staff. Results were available from survey completed by people and their relatives in July 2017 that showed 84% of respondents were "very satisfied or extremely satisfied" with the service provision. Some of the survey comments included, "I am very happy with everything", "Staff work very hard and are very kind" and I am delighted to see the renovation works taking place." Results from the staff survey in the same period, with a 60% response rate, showed that all staff were "satisfied or extremely satisfied" with their job. 75% of the staff team had rated the quality of care provided by the home as "good or excellent." Comments from staff in the staff survey included, "I enjoy my job", "Northlands is a better place to work now" and "Teamwork has improved." Where suggestions in surveys had been made for improvements these had been actioned and the results advertised showing what respondents had said and the action taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

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